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PUBLIC HEALTH NURSING

VOL. 37, NO. 8 AUGUST 1945

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PUBLIC HEALTH NURSING

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NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

1790 Broadway, New York 19, N. Y.

The National Organization for Public Health Nursing is a membership organization composed of individual and agency members. Its purpose is to serve as a clearing house of information, and to develop and interpret standards for personnel and practices in public health nursing. This is accomplished through an advisory service to individuals and agencies interested in public health nursing; through publications, including the official magazine PUBLIC HEALTH NURSING; and through connections with national, state, and local agencies in related fields. The organization is administered by an elected board of lay and professional members and its activities are carried on by committees representing public health nursing and related fields, and by an employed staff.

The organization has no jurisdiction over its membership. It serves in a purely advisory capacity and the acceptance of any of its recommendations is entirely voluntary.

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**Federal Register, June 7, 1941, p. 2762*

***Release, July 2, 1945, Agricultural Research Administration, U. S. Department of Agriculture*

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But a penny has such little value today—what manner of candy can it buy? Yet the little boy finds it hard to make his choice. Among others, there are peanut squares and malted milk balls, chocolate fudge and wrapped caramels, and peanut butter roll.

Nutritionwise, what does his penny buy the little chap? He does not realize it, but in such candies there are 52 calories, and there is good protein (0.9 Gm.), fat (1.74 Gm.), and carbohydrate (8.33 Gm.); calcium (10 mg.), phosphorus (20 mg.), and iron (0.20 mg.); thiamine (0.01 mg.), riboflavin (0.01 mg.), and niacin (0.40 mg.)*

In quantity, of course there is not much of each of these nutrients. But then, a penny is not much either. And besides, is there aught else in the world of which a penny would buy so much?

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Telling Our Story

NEXT to making sure that we have a first-rate public health nursing service, we are—or ought to be—concerned with making that service fully understood by the public. We owe that to the community, for only part of the job is done if the service is used by a small percentage of the people whom it should benefit.

Some of the greatest opportunities for public health nursing lie ahead. Health programs after the war are expected to undergo sizable expansion. But only if the whole community is behind these programs can they hope to be really successful.

Before we can secure better understanding of public health nursing, we ourselves must have a clear realization of what we are trying to accomplish. We want two things most of all: we want stronger citizen support, and we want fuller use of public health nursing service by everybody, because that should mean better health protection for the community.

A few hurdles stand in our way, not the least of which is insufficient funds. An adequate budget for public information is a goal for the future. But in the meantime we can compensate by using to the limits of our ingenuity all possible free and inexpensive means at our disposal. No way of telling our story should be overlooked. One item in the newspapers does not make a public information program. Exhibits, window displays, talks, radio programs, special meetings, films—all these are needed in a well-planned year-round program. Each medium reinforces our message.

Another hurdle sometimes is lack of confidence in our *know-how*—our unfamiliarity with all the necessary techniques. We can gain confidence from the knowledge that public information is a field of many specialties, and that experts in these specialties live in almost every community. We need their point of view. And they are willing to give it if we learn to admit our shortcomings and turn to them more frequently for help and advice.

One authority in the field of public relations has said that if there is one single impression the public now has of health and welfare services it is one of dullness, and that too many of our efforts at interpretation only confirm that impression. Perhaps we err a little on the side of conservatism. As one man asked when interviewed during the public opinion canvass at Des Moines, Iowa, on Public Health Nursing Day, "Why don't the public health nurses advertise more? Then so many people wouldn't die!"

In the final analysis the best interpretation is the kind that comes through actual participation in the public health nursing program. That is one reason why our volunteer programs are of such urgency. It is also the kind of interpretation that all of us can carry on in our daily conversations and daily contacts.

The 1945 Public Health Nursing Day has stimulated countrywide interest in interpretation. Appearing in this issue are two articles, "How to Use Movies" by Dr. H. E. Kleinschmidt (page 392) and "How One VNA Board Met Its Public" by Mrs. John Normile (page 382), that should help us to improve our public information programs.

Every person, however remotely connected with public health nursing, is concerned with this responsibility. Every ounce of our initiative and imagination must go into the job of creating public understanding of the need for the best possible health for every individual and of the part the qualified public health nurse does and can play in promoting good health. On adequate, accurate, and inspired interpretation rests, in large part, the future of public health nursing.

E. W.

How One VNA Board Met Its Public

By MRS. JOHN NORMILE

NOT IN THE spirit of 1776 did the Des Moines Public Health Nursing Association plan its annual meeting this year, but in the fashion of the spirit of 1945! The board went out and met its public rather than follow the conventional pattern of asking Mr. and Mrs. Public to attend "just another annual meeting" where reports for the year would be given before a group for the most part fairly well conversant with our work.

The result was as refreshing as the idea—*a public opinion poll on public health nursing*. In doing this we were given the golden opportunity of informing a wide and varied cross-section of our community about the services of the public health nurse.

Our board had voted to use whatever device seemed desirable to take the place of the public annual meeting. After various substitutes were discussed the decision was made to have a public opinion poll, as outlined by NOPHN in its suggestions for the first Public Health Nursing Day. This appealed to us as the most effective medium for telling the greatest number of people about the services our nurses render. In turn, we could learn how much the public knows about us.

Gallup polls have focused the nation's interest on what the man on the busiest street corner thinks, as well as the remotest farmer at his plow. So the poll idea, we thought, would have instant appeal. It would catch the public's fancy, thereby impressing them with the subject that occasioned it. It had punch, and so had value in carrying the idea through.

The preparatory work was handled by a committee composed of the executive officers of the board, two other board members one of whom served as chairman, the director, and a public relations expert.

We selected January 26, the first National Public Health Nursing Day, as the date on which to conduct the poll. We anticipated that any health subject would receive special attention because of the particular significance of the day. National broadcasts would point it up and we would tie in our work as a special local feature. The newspaper did recognise this and we received excellent publicity. Naturally, newspaper men were intrigued with the human interest of the project.

The committee's final conclusion on how best to tell our story through the poll was by directing six questions to each individual we interviewed, the first five being "merely steps" to the lead question which was the sixth—our most important one. Here are the questions we asked:

1. Where do you work?
2. What do you do?
3. Have you used a graduate (trained) or practical nurse in your home?
4. Have you ever used the services of a public health nurse?
5. Would you call a public health nurse if you or your family should ever need part-time nursing care or help in carrying out your doctor's instructions?
6. What is your idea of the services a public health nurse is prepared to give?

These questions we had printed on letter-size paper. As the person answered each question his reply was written down by the interviewer. At the bottom any comment out of the ordinary was jotted down under "Remarks." We were very pleasantly surprised at how few uncomplimentary ones were given.

When the interview was completed, the person interviewed was handed a printed

Mrs. Normile is president of the Board, Public Health Nursing Association of Des Moines, Iowa.

Mrs. Normile (at right) is shown interviewing an office worker "on the job"

pamphlet giving the correct answers to the questions and information about the Association. The pamphlet was planned to be as attractive in appearance as we could design it. We wanted it to have "eye-appeal," so it would not be thrown away. We said, "Thank you for the interview," and added, "Here are the correct answers to the questions. Will you please read them and tell your friends and family about the public health nursing services?"

We considered the pamphlet a vital factor not only in bringing home the points we wished them to remember but in reaching many more people than those directly approached. The interview we counted on as being the stimulant to reading the pamphlet, while the pamphlet was the vehicle that would carry home the information we wished them to know and to remember. Since it is a human trait to be curious about the accuracy of our replies to questions, we expected that the pamphlet would be read with interest and remembered.

The entire membership of our board, with the addition of selected volunteers from our well-baby clinic, were the group who took the poll.

Since it was wintertime, the poll was taken indoors. Places of business and firms in the city were studied by the committee for their size, variety of personnel, and their potential effectiveness in reaching the greatest number of people who we thought might know very little about the services. When the places were finally decided upon, the person or persons assigned to them were asked to get permission to take the poll in the particular building thus assigned. With but one exception this permission was given graciously. In quite a few instances the company or firm made arrangements for desk space where the interviewer, as well as the one interviewed, could sit during the question and answer period.

As an example of the types of places chosen, interviews were conducted in large insurance companies, public utility buildings, department and loop drug stores, banks, packing plants, manufacturers of war materials, and outlying shopping centers, and also in public buildings, such as the main post office, library, and city market. These reflect the wide variety of our locations which in all numbered 20 within the City of Des Moines.

At the end of the day we had polled 628 persons. However, we believe we reached a far greater number than this. We certainly had whipped up an interest that would make the majority pass on to their associates who were not polled and

to their families the information they received.

All questionnaires were turned in to the director's office at the end of the day. Later the committee sifted all replies, first into groups according to the occupation of the person polled. Then they were again tabulated into types of replies. For classification as to employment we made seven divisions. These, with the number interviewed in each class, were: white collar, 309; labor, 136; housewife, 116; self-employed, 21; executive, 36; did not state, 9; and farmer, 1.

To the question, "Have you ever used the services of a public health nurse?" the following said "yes": laborers, 33 percent; self-employed, 24 percent; housewives, 22 percent; white collar workers, 17 percent; executives, 11 percent. Obviously, we need to put more emphasis on interpreting our services to all groups in the community, particularly white collar workers. Housewives, also, should understand better the availability of part-time nursing service since they often make the decisions for the family in regard to care of sick members.

"Would you call a public health nurse . . . ?" This question was not easily answered as several factors are involved. Although 26 percent said "no," this group stating they would seek hospital care or a private duty nurse, some 46 percent said-"yes." This favorably inclined 46 percent is a potential field for giving service. Many of them, as indicated by answers to the previous question, had not up to this time ever called a public health nurse. "What is your idea of the services a public health nurse is prepared to give?" was the key question, but we learned it was often misinterpreted to indicate the professional preparation of the nurse, rather than "what she does." Careful study of the replies at least emphasized that a large part of the community has only a vague idea of our services, or confesses to knowing nothing about it. A large part of the community likewise has thought our services were for charity only, but this is not surprising since that was a large part of our work during the depression years. We have not dared promote our paid service too much for fear we could not have a nursing staff adequate to meet the demands.

Our committee and our board were definitely enthusiastic over the day's results. We all felt it was a project that had brought a number of gratifying results. We acquainted a large number of our citizens with the scope of our services. As a public relations factor it had been truly productive. It had given us the chance to tell many who were uninformed about one of their community's health agencies. It was a completely successful means of creating board interest. Nothing the board has done in years has caused such unity of thought and wholehearted cooperation. The board worked 100 percent strong on this day. The board gained in its own right, too, for as the members were informing others they were being impressed themselves with the extent of the work they represented. It alerted every board member to what the community was thinking about the organization, if they had been thinking about it at all, and where and how we could best interpret to our community the part we play.

Comments from people who regarded public health nursing service as only for those who cannot pay were interesting. A bank officer exclaimed, "You mean, *I* could call a nurse?" and a garage man, "Hell, no, we wouldn't use the public health nurse. We aren't paupers!" People who never knew the service was available to them were extremely grateful for the information. A switchman at a public utility plant said, "If I'd only known of the hourly service four months ago! My wife was ill and unable to get into the hospital or get a nurse. I had to quit work in order to care for her." One man asked, "Why don't the public health nurses advertise more? Then so many people wouldn't die." A supervisor at the telephone company was very interested. "I live alone, so now I'll feel more comfortable in case I get ill."

Other comments were equally informative: "I could never have raised my six children without the public health nurse"—from a woman who worked in a cleaning establishment. "A public health

nurse keeps you alive until the doctor gets there"—from a department store clerk. "I may call the public health nurse some day, when I get to the end of my string"—a housewife. "You are rendering a marvelous service by explaining public health nursing services"—an executive at a utility plant.

Among the comments jotted down was one so frequently given that it became a refrain—and music to our ears. As a "lay person," I may quote this oft-repeated phrase usually spoken at the end of our interview:

"We think the public health nurse is wonderful." And so do we!

Should any other board wish to poll their city may they take this thought from Des Moines, "You'll be fully repaid." It's labor, but of the sort that brings a glow. We all received one, especially as January 26th was the DAY!

The New Britain Poll

AN INFORMAL canvass of public opinion was one of the suggestions made by NOPHN for the first Public Health Nursing Day. In making the suggestion it was well recognized that the polls would probably not be ultra-scientific. The main purpose, however, was not to count noses, but to stimulate more people to thinking about public health nursing, and to help more visiting nurse associations and health departments realize the tremendous job in interpretation that needs to be done.

Many communities experimented with such a canvass—among them New Britain, Connecticut, and Des Moines, Iowa.

In New Britain, Connecticut, polling of organized groups was featured, although some canvassers did poll individuals in a local department store. Organized groups included the Factory Girls' Clubs, College Club, Woman's Club, Teachers College, General Hospital (with a sampling of the medical and graduate nurse staffs, public school teachers, and the Business and Professional Women's Club). Mrs. Curtiss L. Sheldon, chairman of the New Britain "Day" Committee, reports that confusion about who is a public health nurse was evident in almost all replies. As in other communities the public health nurse was most readily identified as a visiting nurse, but she was also known as a county, community, or district nurse. Of the 650 individuals polled, 613 understood that a public health nurse is a registered graduate nurse, while 641 knew she is expected to have special training to be a teacher of health; 631 understood public health nursing as a service for everyone to use, and 596 said they would call a public health nurse if they needed part-time nursing care at home. New Britain's experience showed one or all of three things: (1) that the selected groups polled were much better informed than the average (2) that the public is much better informed about public health nursing than we think (3) that New Britain has done a good job in interpretation. Probably the first and third conclusions are nearest the truth.

In conclusion, Mrs. Sheldon reports, "The results of the poll were encouraging. However, they indicate need for further joint activity among the public health nursing groups, with continuous interpretation of their respective aims and accomplishments."

With this issue a new column, "Public Information Tips," by Edith Wensley makes its appearance in the Magazine. Designed to report what is being done in public information programs throughout the country and suggest what might be done, the column will depend largely upon a pooling of ideas from the field. Turn to page 427 and plan to send us your "tips."

The Dynamics of Mental Hygiene in Industry

By MATTHEW BRODY, M.D.

THE PRESENT war, with its all-out effort, has brought the problem of psychiatric disorders to the fore. One and a half million veterans have already been discharged from the Armed Forces, 30 percent of them, according to military statistics, for neuropsychiatric conditions. This vast number has brought dismay and fear to those obliged to employ them. Many employers have apparently confused the term "psychoneurotic" with "psychotic," and seem to anticipate that a veteran with a psychoneurotic condition, if let loose in a plant, will throw a monkey wrench into the first available machine. The Armed Forces have attempted to allay this apprehension by omitting the diagnosis from the discharge certificate. As far as I can see, this aggravates matters, since things concealed assume an even more dreadful aspect. Industry has always been faced with the problem of the maladjusted individual, but he was not labeled with a fancy diagnosis and so no one was afraid of him.

There is no question as to whether or not industry can utilize psychiatrically handicapped individuals. Industry has been doing it, often without realizing it, and perhaps not as efficiently as it might. Attention has been drawn to the fact that certain undesirable industrial traits, such as absenteeism, frequent job changes, poor work habits, prolonged invalidism, and accident-proneness, may in large measure be due to emotional factors. Yet if industry were at this moment to discharge everyone with a psychiatric disorder, not only would many psychiatrists in private practice have to go on relief, but industry would find itself seriously handicapped. Every psychiatrist can testify that some of their sick people are doing fine jobs in labor, industry, the arts, and sciences.

We should remember, however, that the responsibility for the treatment of these disorders is up to the individual and the community. Industry, even in Russia, is run for profit. Industry can never be run for the sole purpose of occupational therapy. The major problems that psychiatry has to aid industry solve are: (1) to devise means of separating the wheat from the chaff, the large numbers of employables from the small numbers of unemployables and (2) to improve methods of job placement and handling of the emotionally handicapped. The psychiatrist will be of greatest use by acting in an advisory and consulting capacity to the medical staff, the personnel department, and indirectly to the supervisory personnel.

A word about the responsibilities of a psychiatrist in industry. They are that of any industrial physician, except that they are along the special lines for which his training has equipped him. The industrial physician has three main functions: (1) to assist in the placement of applicants for employment (2) to treat any medical emergency that occurs among the employees while at work, and any condition that arises out of working conditions and (3) to initiate any program that will prevent or diminish mental and physical illness among the workers.

Dr. Brody is consulting neuropsychiatrist, Sperry Gyroscope Company, Brooklyn, New York.

In brief, as in the Army, he is responsible for keeping as many people at work as possible.

There are important differences between the mental and physical requirements of the Armed Forces and of industry. The Armed Forces obligate themselves to treat almost any condition that arises while the man is in uniform. This may entail prolonged hospitalization, the utilization of expensive equipment and skilled manpower, often evacuation over distances that may cover half the globe, and pensions for permanent disabilities. Also, the fighting man must be capable of withstanding tremendous physical and mental strains, including the threat of death. Industry makes no such demands, and assumes none of these obligations. It is quite obvious, then, that entirely different criteria for employability are needed in industry.

THE PSYCHIATRIST AND PLACEMENT

When labor is plentiful, the industrial physician can ease things for himself and his company by a rigid system of selection of employees. During the present emergency, however, with the shortage of manpower, his ability to select is sharply curtailed, and he must utilize the residue left by the Armed Forces.

In a small plant the question of placement, of matching the applicant to the job, is simple. The proprietor knows every job in the plant, and a little about the personalities involved. It is relatively easy for him to know in advance that John Doe will fit in and can do the job in question. When plants become larger, types of jobs more numerous, and the question of interpersonal relationships more complex, then the employment interviewer finds himself almost in the position of placing a man he has just met into a job he does not know, to get along with personalities he knows only by a serial number. To counteract this, comparatively complicated placement procedures have evolved that are making personnel work a profession. But the problem still resolves itself to sizing up the job, sizing up the applicant, and matching them.

JOB REQUIREMENTS

Each job has certain requirements, or demands. These are:

1. *The physical demands of the job and its environment.* The United States Employment Service of the War Manpower Commission has worked out a careful job-analysis scheme. As jobs become more specialized, fewer physical requirements are demanded. These requirements are specifically stated, both for the job itself and for the working conditions. From twenty to thirty different items are included under physical activities (such as walking, balancing, sitting, handling, fingering, seeing, hearing, depth perception, and so forth) and a similar number under working conditions (as inside or outside, hot, cold, dry, noisy, dusty, hazardous, working with others, and so forth). A surprising number of jobs will be found that will require but one arm, no vision, or no hearing, and so on.

2. *The intellectual demands of the job.* This requires only a rough approximation which can be determined by finding out roughly the intellectual level of those best performing a certain job. It is as much a mistake to place too bright an individual as too dull a one on a job. The bright one becomes bored, careless, and indifferent. The excessively dull may seek any of the compromises and escapes known to psychiatry to preserve his ego rather than acknowledge his inferiority.

2. *The technical demands of the job.* The best judge of this is the supervisor, who can also determine whether the applicant has the necessary experience and skill. This applies especially to the more highly skilled jobs. I would no more attempt to decide whether or not a man is a good tool-and-die worker than I would expect a hospital steward to choose a clinical director or a pathologist.

4. *Intangible factors.* These include the emotional demands of the job. We confess our inability to determine all of these factors. We know of no way of doing a Rorschach on a job. We are doing the best we can. If we knew all the answers, we would know why some people make good policemen and others good

barbers. We would not hesitate to employ an effeminate individual as an illustrator or in certain types of clerical positions. We would refrain from putting him into the foundry. We have found that we cannot place persons with perfectionistic tendencies in certain departments in our concern, but we are not certain of the reason. An interesting illustration is the experience of the British Army. One would suppose that the person best suited to drive a tank would be one with previous mechanical and driving experience. Yet cab drivers did poorly in tanks. Apparently the taxi drivers were accustomed, all of their lives, to stay in line and avoid collision. The tank requires a crashing, destructive tendency which has been trained out of cab drivers. It is these intangible factors that make an ideally complete job analysis difficult.

The job analyst is responsible for compiling these job requirements for each job, and the results are compiled in a manual accessible in the employment office.

INDIVIDUAL CAPACITIES

What has been done with the job must now be done with the prospective employee. This is done by the employment interviewer with the aid of the medical department and various specialists, including a neuropsychiatrist. The individual is studied to discover what his capacities are, and the outline follows that of the job requirements. These are:

1. *Physical assets.* The interviewer is furnished with a comprehensive medical diagnosis from which he determines what the applicant's physical assets are. The interviewer's attitude is a positive one. If a man is deaf, he can still walk, finger, employ a known amount of depth perception, and so on. As a matter of fact, he is at an advantage in a noisy environment. Using this type of approach and attitude, the placement of the physically handicapped is a comparatively simple proposition. Where difficulties are encountered, one can presume that emotional complications are interfering.

2. *Intellectual assets.* In this part of the country, where schooling is universal, the applicant's rate of progress in school is usually a sufficiently satisfactory index of his intelligence. Where required, brief psychometric examinations may be performed. We believe that too great an attempt at accuracy in this regard with all employees is unnecessary and involves an excessive expense.

3. *Technical skills and experience.* These are brought to the attention of the prospective supervisor, who is the final judge.

4. *Emotional assets.* We use this term deliberately because we have found to our dismay that psychiatric diagnoses by themselves are not the sole criteria in placement. Ordinarily one would presume that the psychotic is universally unemployable. This is not entirely true. Illustration will be instructive.

Sometime ago, a veteran applied for work at Sperry. Although neatly dressed, his speech and thought were so disorganized, and his affect so flattened, that I asked him if he would return with a member of his family. His father was in the waiting room with him. We learned that he had been discharged from a state hospital five years before. A little over three years ago, he enlisted in the marines, and served two and a half months, just long enough to be recognized as a deteriorated præcox and discharged. Since then he had been steadily employed elsewhere as a machinist, earning $90 a week. He had never missed any time from work, had saved his money, and had never been in any difficulty. We confirmed this story and employed him as a machinist, and so far he is doing well, although his colleagues consider him queer.

On the other hand, we had a former Sperry employee who served eleven days in the Navy. Prior to his induction, his supervisors were having increasing difficulty with him. Because of his seniority, and because he was due to be drafted, he was tolerated in order to protect his military-leave bonus. Upon his return, however, he objected to the routine reexamination procedure, and in particular to the vision test. He was brought to another plant to have the vision test

repeated. The oculist felt that he was having difficulty in passing the test for emotional reasons. His attitude was so bizarre in the employment office that he was asked to see me. He was mildly paranoid, but his trends were directed against the company and the supervisors. Because of his veteran's status, and our legal and moral obligation, he was reinstated into his former position, with the understanding that he was to see me regularly. He soon developed trends against his machine. His work fell off, and the problem of supervision became insolvable. I prevailed upon him, I thought, to take a medical leave of absence in order to enter an institution for treatment. Apparently he changed his mind and notified the Selective Service System that we had given him a medical leave rather than a release only to prevent him from working elsewhere. We had to dismiss him.

I chose these two cases deliberately, not so much to demonstrate that schizophrenics are occasionally employable—as indeed they rarely are—but to show that a psychiatric diagnosis by itself is of little use in industry. These two men suffered from like conditions, one is employable; the second, and probably the least sick, proved unmanageable. This holds true for every psychiatric classification, although with the psychoneurotics, the percentage of unemployables is smaller.

So we have instructed our employment interviewers that they can almost disregard any history of a nervous breakdown. We have told them that, as a matter of fact, certain types of psychiatric liabilities, such as obsessiveness, perfectionistic traits, and so on, if properly channelized, may constitute industrial assets. We object to an exclusively cross-sectional view of an applicant and demand that he be viewed from the longitudinal point of view. Consequently we feel that the employment interview, properly conducted, constitutes the best guide as to placement, although we are experimenting with group Rorschachs, and so on.

The employment interviewer is instructed to adopt the neutral attitude and to permit the applicant to tell his own story as much as possible. In evaluation, emphasis is placed upon his previous work history, and his previous school history. If he is a veteran, his Army record is examined for evidence of leadership shown and special skills learned. We are interested in the attitudes he has shown to persons in authority. We are interested in evidence of maturity and responsibility as shown by his marital status, his savings, and his attempt to establish a home. What his attitudes are to himself and to any defect present are also noted. If he is a veteran, the length of time it has taken him to apply for a job is significant. Generally speaking, the sooner a veteran wants to begin work, the better his prospects. The veteran who has to rest at home, for vague reasons, is often a psychoneurotic who lacks insight and is fleeing from his problems. On the other hand, the veteran who states that his nerves were shot and so he did not want to work, but that now he feels better, at least has some insight and is making an attempt to face his difficulties. Should there be any question, the employment interviewer is free to request a psychiatric consultation. This serves a double purpose. First, specific advice is given on the problem. Second, the discussion that follows the consultation points out the factors involved and aids the interviewer in his orientation.

All the above must seem like a cumbersome process, but actually it works out quite smoothly. When a former employee applies for reinstatement after discharge from the Armed Forces, the problem is much simpler. We know what he has done in the past. Also, the applicant knows what the job was, and the mere fact that he is reapplying shows that he was happy with the former placement. When the former job is no longer present, or when the physical or mental status of the applicant has so changed that he is not the same person as he was previously, it is necessary to make a new placement.

The applicant who is referred to me for evaluation is told that he is being referred to a psychiatrist in order to achieve a more suitable placement. The suggestion

made by some that the industrial psychiatrist ought to mask his identity under some other description, such as plant physician, and so forth, smells to me like chicanery and intellectual dishonesty, the result of personal feelings of inadequacy. I have found no resentment in any one referred to me. On the contrary, a few veterans have complained that they have not been "psyched" and do not want to be left out. The employee is under no compulsion, and what he reveals is considered confidential except for the brief report sent. Not a few have requested further interviews.

So far as employment prognosis is concerned, I rely chiefly upon an evaluation of the *previous work record.* Where a neuropsychiatric condition is present, consideration is given to acuteness of onset, severity of precipitating factors, previous personality, duration of illness, adequacy of treatment, presence of affective features, whether or not improvement is continuing, presence of some degree of insight, and what the motivations are that determined the man's return to work. The presence of antisocial trends generally precludes employment. Accident-proneness is considered a bar to employment. Psychopaths may be employed if they can be without expenditure of money for training. Epileptics may be employed in certain sheltered situations, if they have an aura, are under treatment, and are capable of handling themselves in case of a fit.

In a few instances veterans have returned prematurely, but examination indicated that they were improving and would be ready for work at a later date. These veterans were so informed. Some of these were given stopgap jobs until they were ready to return to their former jobs.

After placement, a follow-up is maintained by the employment interviewer, the supervisor, and, in the case of veterans, by a veterans' counselor. If for any reason the placement appears poor, reassignment or other adjustments are made. This attitude that mistakes will be made enables all concerned to learn from mistakes.

THE PSYCHIATRIST AND SUPERVISION

The crux of any rehabilitation program, after placement, is the supervisory personnel. The supervisor sets the morale of the department, and can make or break any rehabilitation program. Apprehensions arising from misconceptions of the psychoneurotic concern him. He must get out production and fears any one labelled as a "nut." To allay these fears, we have been addressing foremen on the subject of psychoneuroses, mainly for the purpose of reassurance. In addition, educational slide films have been prepared. Technical terms are avoided. We assure them that the problems they will face with the returning veteran are no different from those they handled previously. They are given simple and sensible instructions. Where a problem gets beyond them, the personnel department is available for help as are the veterans' counselor, the medical department, and the psychiatrist.

In the lectures, anxiety is explained. They are told that in most instances the conflict is resolved by discharge from the service. They are warned that curious questioning and unskilled probing may rub the wrong way. Griping is explained as being due to a combination of two variables—the manifest content and the latent. The manifest content must be investigated. The latent content is due to emotional factors not necessarily connected with work and is often benefitted merely by permitting the employee to blow off steam. They are told that psychotic states are rare. They are warned of the guilt feelings that follow discharge and of the necessity of rebuilding a new group spirit quickly. The emotional adjustments and reorientation that must be made by the veteran when he returns to his home and to work are explained. Supervisors are enjoined to be patient. They are told that it takes a year of military training to make a soldier out of a civilian, and that it will take a period of "peacetime training" to readjust him to civilian life. The placement program is fully explained. These lectures have found an enthusiastic reception.

PSYCHOTHERAPY IN INDUSTRY

The lectures and consulting service have resulted in a valuable educational program that has benefitted the medical department, the personnel department, and the supervisory personnel, affording them a valuable insight that has enabled them to recognize emotional problems at the beginning. The simpler problems thus have been resolved more readily. No formal psychotherapy has been attempted, although of course one cannot conduct a psychiatric interview without giving some aid and comfort. Where psychotherapy was deemed advisable, the patient was referred to a private physician or an outside agency. We hope that the facilities available for psychotherapy in the community will be expanded after the war. So far as veterans are concerned, there are a few clinics doing a commendable job, but they are swamped by appeals for help. I hope that the Veterans Administration will be able to offer outpatient psychiatric care. The firm that I represent has arrangements with a private sanitarium by means of which we can handle those of our employees who require a short period of institutionalization under our group-hospitalization plan.

The ability of an employee to let off steam by griping and an understanding on the part of the supervisors of the nature of griping provide a helpful release of emotional tension, and often uncover employment situations that require correction. The filing of grievances is a more formal step in the same direction. The suggestion system offers an opportunity to make positive contributions to the company, and the labor-management committees give both parties an opportunity to understand seemingly contradictory points of view, which around the conference table do not turn out to be quite so contradictory.

CONCLUSION

The exigencies of war are bringing industrial psychiatric problems to our attention. Mental hygiene in industry must utilize as much as possible facilities already present in industry. Psychiatrists can contribute much to proper placement and better labor-management relationship by an educational program and by acting in a consultant capacity. This program should attempt to improve the employment interview, methods of placement, and supervision. Aside from the financial savings inherent in such a program, which we feel are considerable, the saving in human values is inestimable. Enlightened management, which looks upon good labor-management relationship as important not only to the community, but financially important to the company as well, will be quick to inaugurate such programs.

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PULMONARY tuberculosis during childhood arises largely from an infection acquired within the household. The source case, the open chronic case of pulmonary tuberculosis whose symptoms so often masquerade under the title of "chronic bronchitis," is a menace to the child and to the community. The detection and control of these chronic carriers of the tubercle bacillus become, with the reduction in the incidence of tuberculous infection, procedures of great importance. We have accepted for too long a period the harmful freedom of these patients, harmful to the individual and to the community. We have accepted with an equanimity which does little credit to our sense of the value of preventive activity the fatalities in childhood tuberculosis and pneumonic adolescent phthisis which have their inception in the contacts which this freedom determines.

J. E. GEDDES, M.D.,
NAPT Bulletin (London), April 1945

How To Use Movies

By H. E. KLEINSCHMIDT, M.D.

THE MOVIE is the health worker's ambassador of good will, reaching pleasantly many groups not easily accessible through other channels. The man-on-the-street is an evasive fellow and hard to corral, but he belongs to groups of one kind or another—club, congregation, union; he attends meetings and welcomes a good show. The movie builds public support, not only for the project or cause which it presents but also for its sponsor, your organization. A good movie is a superb educator; you may be sure that the producer has selected the subject matter carefully and compressed a maximum of information into a minimum of film footage. You, of course, supply the personality so essential to the promotion of public relations, but the movie supplies the visual support and sharpens your message.

But these assets are all premised on how well your ambassador is chosen and presented. Inept choice or use of a movie can ruinously alienate good will. Many an eager health worker, having caught the idea that the cinema may be a valuable aid, has seized upon it only to learn, bitterly, that many movies offered him are mediocre in quality and, yet more disconcerting, that craftsmanship of a type not taught in any school is necessary to get the value out of even a good movie.

We are on the eve of a great upsurge of interest in educational movies, and health workers must prepare themselves to take advantage of it, or risk the seizure of nontheatrical films by commercial and entertainment interests. Just as soon as priorities on cinema equipment are lifted new projectors, better than those we have had heretofore, will flood the market. Stimulated by the success achieved by the documentary films of Great Britain in mobilizing the people as a solid war unit, and by the effectiveness of training films created by the U. S. Navy, U. S. Army and other governmental departments, community agencies and educators will doubtless demand wider use of the cinema. Large numbers of technicians skilled in movie production and bristling with new ideas will be released for civilian service. The postwar stage is set; unless the crystal ball betrays us, both supply and demand will be accelerated, greatly to the advantage of the health promoter.

Meantime, what must we know and do in order to derive the utmost value from the health film? The first and most obvious requirement is that we practice good showman technic. The way in which non-theatrical movies are now, too commonly, offered to the public would make old P. T. Barnum weep. "Now we'll have the movie," says the speaker, sweetly. There is a clatter at the projector, the operator trips over wires, doors bang, wheels whir, ominous grunts emanate from the loud speaker. Someone volunteers to pull down the screen, another awkwardly yanks at the window shades, a third fumbles for the electric switch. Everybody shuffles expectantly. At long last some dizzy flickers appear on the screen. The picture is out of focus and out of frame and of a dull, illegible gray because too much daylight filters into the room. The picture is well on its way before the sound appears, and it comes suddenly in a thunderous burst, until the operator gets it adjusted (or does he?). And not until the reel has almost run its course does he finally get all working smoothly. All this time the door of his projector has been open and the noise has made it almost impossible for those sitting

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near the projector to hear the film. These are just a few of the gaucheries we put up with (folks are certainly patient) and much worse situations could be described.

How different this technic is from the good form you observe when you are invited to speak before the Ladies Browning Society or the Stevedores Chess and Chowder Club. You come immaculately groomed. You have your material well in hand. The chairman gives you a pleasant introduction and the audience is quiet and respectful. Your very first word, spoken with a smile, is a gracious one, and nothing is allowed to disturb the flow of your story. You don't scream, nor mumble, nor use bad grammar, and when you finish your charm has captured the group. You have made a good impression —for yourself and your cause or organization. Putting on a good movie show should be done with the same kind of grace and smoothness, and that means careful planning and checking of all details in advance. These details are not minor ones which may be left haphazardly to the office boy or to the student hastily called from the manual training class.*

Equally important is the wise choice of the movies to be used. At the present time that is difficult. While there are hundreds of films on health, nutrition, and safety, there is no one central agency competent to advise us on the quality of these films. The dozens of catalogs available have value in *locating* films for us but the films listed are not critically *evaluated.* Therefore, it becomes necessary for the film user to make her own selections. Incidentally, the demand for a more rational distribution system is becoming so insistent we may hope that responsible leaders will soon effect some kind of organization which will bring order out of the present chaos. And with that must also be developed standards for judging teaching movies and of making their strong and weak points known to users, as at present books are reviewed for prospective readers. But even when all that has been effected, the art of program planning and of good showmanship must be mastered by the health worker of tomorrow. We should know, for example, the different types of films and know how and when to use each.

1. The *drama* film is a story in pictures and it has a plot. Woven into the story are the lessons the producer wishes to teach.

Too many films consist merely of a safely stereotyped plot on which the facts the propagandist wishes to offer are hung like so many ornaments on a Christmas tree. Hollywood calls that "spinach" and will have none of it. The "lessons" should be "woven into the story," not "hung" onto it. If the particular idea to be taught can itself be made the dramatic element and without torturing the plot, the film is a good teaching tool. It is possible, for example, to teach much about tuberculosis by introducing it as an interloper which wrecks the plans of two young people who then work their way to a satisfactory solution. The drama film is useful too in conveying emotional impulses. Sometimes only fiction, drama, fancy can deliver the truth in its real meaning. Has the value, dignity, and humanity of neighborliness, for example, ever been better impressed than by telling the story of the Good Samaritan?

2. The *comic,* an essential of every theatrical show, lends itself to teaching certain truths. One must guard, however, against the movie which is so funny as to detract from its real purpose. Caricaturization can easily mislead ingenuous minds, or fill them with false concepts which later have to be uprooted. Is it good pedagogy, one might ask, to picture the heart as a pump, to personalize a germ, to represent penicillin as a bullet? The answer depends much upon the way it is done.

3. The *documentary* film describes things or situations as they actually are. The term is a poor one and probably derives from the practice of authors of verifying or "documenting" their statements. In essence the documentary is the equivalent of a journalistic tour, a critical inspection, or a laboratory demonstration. It shows actual situations and real people

*See "Putting on Your Show" by Elsa Volckmann, *Channels,* April-May 1945, p. 11.

who are part of them and at home in their surroundings. The strength of the documentary film depends upon the faithfulness with which things as they are, are recorded and without histrionic embellishment, together with a synthesis or interpretation of the sights seen. Most professional workers accustomed to Hollywood methods find this irksome and not quite cricket. Once I was amused by the spontaneous praise of a veteran cameraman when he viewed an actual hospital scene. "It's so good" he said, "it looks like a real set." Now a "set" is merely the imitation of a real background, so according to his habit of thought, the imitation is reality and the more the real resembles the imitation, the better. That the people appreciate documentary type films is attested by the success of "March of Time" and numerous "specialty shorts."

4. The *training* film shows how things are done. It has proved to be a boon for the Armed Forces who have to learn new skills and in a short period of time. Once a good demonstrator has transferred his lesson to celluloid, he multiplies himself, as a teacher, a thousandfold. Without the training film we should never have been able to prepare 11 million men in time to meet the enemy victoriously. Industry too finds the training film useful for teaching technics to new workers. Although limited in scope, there is a field for the training film in health education.

5. The *lecture* film is mentioned primarily to be condemned. It is the creation, usually, of a specialist who knows his subject but not the art of telling it visually. Words are his tools and he handles them with skill. Using these accustomed tools, he writes a lecture on his subject and this lecture is then illustrated by a movie-maker more interested, perhaps, in turning an honest dollar than in art or teaching. Lacking the imagination to visualize the subject, he hires a handsome actor fellow to speak the lecture. On the screen we see him, now in a close-up and again in a long shot, on the platform. He is immaculately tailored, his gestures are faultless, his enunciation is perfect. But he looks self-conscious and a little frightened, indeed, foolish—for one *does* feel very foolish orating directly into the camera's eye with Klieg lights blazing all about and none but the crew, with tongue in cheek, listening. To relieve the boredom the camera cuts back now and then to the select audience, registering surprise, resolution, approval—all the stock reactions described in the rhetoric book, while the lecturer's voice drones on. But of the subject itself we may see nothing.

6. That is not to say, however, that the *narrative* film is a poor teaching device. On the contrary, it is one of our best. And, fortunately, good narrative films need not be expensive because the photography may be done in "silent" form while the sound is added later in the studio. This, if the subject matter is such that it can be done well, is far less complicated and costly than recording sound synchronized with the picture. The point is that the picture must tell the story, aided and amplified by the words to be sure; but unless the combined effect is a visual impression the product is not a teaching movie but a canned lecture embellished with a potpourri of pictures. One way of testing the validity of a narrative film is to try it out on two guinea pigs; A views the picture without sound and B listens to the sound without the picture. Then both tell what they learned. If it is a good film the chances are that A will return a more complete, correct, and vivid version than B.

This may be the place to condemn, with a few exceptions, the spawn of films showing surgical operations. No one learns surgery from such films. They are usually made by fixing the camera in place in the operating room with the lens focused on the site of the operation and then running the film steadily as the surgeon works. Unless one knows precisely what in particular to look for in the kaleidoscopic scenes that result, he does not see it. The surgeon's hands get in the way, tissues are indistinguishable and the really important steps in the technic, dependent on the sense of touch usually, are not shown at all. If the picture is made in Kodachrome one sees a gory mass

of tissues and glittering metal instruments and highlighted rubber gloves darting hither and yon. All that such pictures demonstrate is that Doctor X performed a brilliant operation, and successfully, too, for the final shot shows the smiling patient convalescing in the sun parlor. Certain subjects simply do not lend themselves to exposition by the motion picture and they should be avoided.

7. The *animated diagram* is capable of making visual, actions and mechanisms hidden to the eye; capable even of visualizing abstractions. With the animated diagram the artist is able to control the several elements of the scene, stilling one motion while another goes on, eliminating structures that are unessential, simplifying, enlarging, decreasing according to the demands of clarity. Unfortunately good animation is very expensive and specialists competent to do the work are scarce; hence much of the animation one sees in educational films is shoddy. A whole chapter might be devoted to the teaching possibilities of the animated diagram. Max Broedel, dean of American medical illustrators, said that a good anatomical drawing depicts structures, not as the eye, but as the mind sees them. That, too, is the function of the animated diagram.

Such general classification of movies is useful but should not be applied too rigidly. Some movies partake of two or more of these styles and some are in a class by themselves. What is more important is to be competent to *judge the value* of a movie. The applause meter may measure the popularity of a given movie but it tells us nothing of its educational value. Besides, the sponsor of the film must know its qualities in advance. Following are a few criteria which may help the sponsor to judge the worth of a movie.

1. The first demand of a teaching film is that it *visualize*—that is, convey a picture image to the mind. Don't suppose that that is easy. The camera lens faithfully records what it sees but the image must exist first in the mind of him who focuses the lens. If the image (idea) is not there, neither will it appear on the exposed film although the scenic effect may be beautiful. Nor is it easy for most educated people to judge whether or not a movie actually visualizes the subject. All our lives, most of us who read this magazine have used words to convey meaning—by means of words we were taught and so facile have we become in the use of words that the visual sense has all but atrophied. Visual education has lagged as a science probably because most educators are word-minded—for which the good Gutenberg is largely responsible. What is the difference between the auditory and the visual impression?

Words are the artificial creation of civilized man. Primitive man first wrote in pictures and then in hieroglyphics which are symbols of things and ideas. The alphabet forced hieroglyphics aside because of the wider possibilities and greater flexibility of letters that can be combined to form words, but to this day the "image" of a thing or of a complicated process is grasped with greater ease, particularly by persons of lesser education, than a word description. "A cylinder of metal or other material threaded or grooved in an advancing spiral on its external surface, and usually fitted with a slotted head," is a model of word precision; but would your carpenter recognize it as a screw?

In short, words are auditory symbols invented for the transmission of thoughts and each sentence must be "decoded" before the thought emerges. While language is amazingly flexible and precise, it is also exceedingly complex. Minds accustomed by long practice to the use of words find them to be adequate for purposes of communication, but for the majority language is a highly artificial transmission line and not nearly as eloquent as visualization. It is significant that the expression, "I see," is synonymous with, "I understand," even when spoken by the scholar.

Disregard for these principles accounts for many of our poorer movies. The health specialist writes a speech; the producer thinks up pictures which he believes illustrate the words—both are pleased with the product. But, alas, the people who see the picture do not "visualize" what was in the health expert's mind. Per-

haps they do grasp the general thesis but only because they understand the words. How much better the words would be alone, undisturbed by distracting pictures which arouse emotions in the minds of the onlookers wholly unrelated to the words to which they are married. The result is confusion. Two sets of ideas rush to the mind simultaneously, one via the ear, the other through the eye; they clash and the mind is befuddled.

2. A second demand to make of the film is that the subject matter be *well selected, organized, and balanced.* That is not difficult to determine if the teacher is master of the subject, and, if she is not, she can easily secure the counsel of one who specializes in the subject. Too often the producer is tempted to film that which is obviously pictorial and to omit other phases of the subject which are not "photogenic." His job, of course, is to find the means of visualizing what cannot be actually photographed.

3. The sponsor has a right to expect reasonably *good cinema technic.* Hollywood ostentation is not essential to good photography but artistry, craftsmanship, and good equipment are. Professional equipment and experts can be rented and there is now little excuse for poor photography. Most of us have a fair working knowledge of photography and are able to judge the quality of photos. But that is not enough. The producer uses single shots as a writer uses words. The ways in which words are built up and put together into sentence structure are governed by rules. There are rules of spelling and grammar in the motion picture art as well. They govern the opening of a scene, its development, transition to the next scene and so on. How does one pass from a long shot to a close-up? When is it good taste to use a "colossal" (camermen like to torment the director by asking if the colossal shall be a big, medium, or small one)? Under what circumstances is it necessary to "pan," to "truck up," to "fade out," to "dissolve," to "cut"? Those who look at movies need not know the cinema grammar any more than they need formal grammar in order to understand their native tongue, but it might be well for those who select and exhibit teaching films to learn the elementary rules of spelling and grammar of the film language in order better to judge the quality of the aids they select.

Sequence is highly important. One scene should lead naturally and smoothly to the next without abruptness and without boresome lingering. Sequence means not necessarily a chronological record of events but an orderly arrangement of episodes that serves best the logical progress of the train of thought. Through entertainment films we are familiar with cutbacks, scenes within scenes, and other devices. When properly done they do not disturb continuity. The entire story of "Mrs. Parkington" takes place on a single Christmas Eve yet by means of flash-backs and parentheses almost a century of related events is covered—the sequence is not a chronological one but a story-structural one. It should not be difficult for the health educator to become expert in judging film sequence for essentially it is no different than outlining a lesson, point by point.

4. The user of teaching films has a right to demand *scientific accuracy.* No producer deliberately releases a film containing glaring errors, if for no other reason than that he is deluged with bushels of uncomplimentary fan mail. (Nothing seems to exhilarate an American more than to spot a movie boner.) But accuracy demands more than sticking to the literal text. Proponents of this or that can, by a clever arrangement of isolated facts and figures, lead one to reach wholly false conclusions. Not all so-called commercial and propaganda films resort to such unethical tricks but it must be difficult for a cheese manufacturer, let us say, to expound the subject of nutrition without giving the impression that cheese is more important in the diet than it really is. Having myself for several years focused attention on tuberculosis, I know how hard it is to admit that syphilis, too, and alcohol and poverty and hangnails may be potent causes of human misery. The good film will be balanced in emphasis so that the whole, rounded picture emerges at the end. It should not be difficult for

the teacher, familiar with the subject matter, to size up the symmetry of a given movie.

These are some of the qualities the sponsor has a right to expect of teaching and promotional films. Better movies will come when users demonstrate their ability to judge them and when discrimination of the users weeds out the inferior and rewards those that excel. The owner of a theater has a relatively easy job. Box office appeal is his single criterion and that is measurable in dimes and dollars. The health worker uses movies to teach—and who is so wise as to tell what education really is! But as Hollywood responds to the demands of the exhibitor, so the creators of educational films will in time fulfill the needs of the health worker.

Using Punch Cards in Time Study

THE Visiting Nurse Association of Trenton, New Jersey, recently undertook to use McBee Keysort punch cards for a time analysis. This was done at the request of Dorothy E. Wiesner, statistician of the National Organization for Public Health Nursing.

For the small agency the McBee Keysort card system for time and cost studies has proved superior to previous methods for accumulating data. The punch card provides holes for entering 73 classifications. Posting the time data from the day sheets to the punch cards is less time consuming than using the usual large posting sheets. The 73 holes make possible a more complete analysis of agency functions. Productive and nonproductive time can be studied readily. Actual tabulation of the cards is a simple hand operation.

On posting sheets one column must be given to every activity, whether it occurs once in a month's time study or whether it occurs daily in each nurse's day sheet. With the punch card, however, the usual activity can be written in a space allowed for unusual activities and the kind of activity and number of minutes will appear only in the final tabulations.

In Trenton all data from daily time sheets had previously been transferred to large posting sheets for the most part by the director herself. Days on which the nurse spent her entire time in the field were used to determine the total number of visits possible per day and the average time spent for each type of service. With the punch card it was possible to do this. It was very much easier to make certain that individual day sheets were accurate in the total number of minutes accounted for. The director was able to train a volunteer to transfer the data from day sheets to punch cards, checking that each day sheet accounted for the correct number of minutes.

While it is true that findings from one month's study may not give an adequate picture of time and costs for the whole year, successive studies made in different seasons will show the effects of seasonal changes on time distribution and on costs.

For some time the Trenton Visiting Nurse Association has been convinced that the present methods of making cost per visit studies have not been adequate to show actual costs. Agencies giving bedside care to a great many patients will not compare favorably in their cost per visit with those having more generalized programs.

Difficult transportation, not-at-home visits, and adequacy of personnel for the size of the community, as well as the number of aged patients cared for, will cause great variations in the time per visit. Attempts are being made now by the NOPHN Cost Analyses Committee to arrive at a cost per productive hour. This figure should be useful both for selling services on an hourly basis and for comparing with the average cost per visit which has been figured for so many years.

GRACE UNZICKER, R.N., EXECUTIVE DIRECTOR
VNA OF TRENTON, N. J.

Tale of a Nurse's Bag

By NATHALIE VOGE, R.N.

THE Health Department ordered me from a bagmaker and I arrived in Marinette City during the bitter cold winter months that are only known by true northerners.

My first owner was the City Nurse, and she was pleased with me but rather disappointed in my color. I was a nice, shiny brown and for some unknown reason she wanted me black. Why, who knows? Maybe it was because her uniform was blue. My future brothers probably won't even be as nice as I am, for "I" am prewar material.

However, she lost no time in finding every corner of me valuable. In one section state literature was placed. At first I was a bit concerned. I certainly didn't want to be used to carry only books. But next I began to receive a supply of articles that I later discovered were to be used for home visits. What in the world would she use all that for? Never even heard of a thermometer before, but that's what she called it. By the time she was through, I must have gained at least two pounds.

Next she carried me out and put me in the corner of the Board of Education school car, which, I later discovered, was used by the City Nurse. I was thrilled and excited—all ready to take my first ride. Where would I go and who would use my supplies first?

Now I dare say I sat in my place at least two weeks—imagine, just sat! Oh, she was aware of my presence all right, for she glanced at me now and then and wore an expression of pity. Apparently she just did not have time to use me. All I seemed to do was sit in front of schools and wait for her to go in and out. I heard her say she thought she ought to spend less time in the school buildings and more out in people's homes.

And lo and behold! One snowy morning she returned to the car and picked me up. I was being carried into a home. My leather was stubborn and stiff from just sitting and not being used. She was very considerate of me, however, for she even put a piece of newspaper down on the table for me to sit on. Then she removed some towels and a bottle and left me, closing my lid so as not to expose my insides to the two little children who were watching me curiously. Apparently, my belongings were pretty precious to her for when she returned her hands had been washed. Then she removed more of my supplies and left me alone again on the corner of the table. That was my chance to see just what I was being used for. Why, heaven sakes—a baby! It looked almost as new as I felt. Next I discovered my belongings were returned to me and all clean—my bottles of soap and alcohol, shears, thermometer, scale, and apron. Then off I went again back to my seat in the car.

Now just how long was I to sit before she would use me again? This trip today was fun. Even the nurse had a big smile as she put me back.

I practically had dust all over me by the time I was used again. However, on my second trip I was as proud as punch. I was displayed in front of thirty little boys and girls in a classroom. The nurse showed them what I contained and asked them questions. They were smart, for they knew many of the answers. I did not mind going back to my corner that morning. I felt proud. At least some people knew I existed.

Then along came summer—thank goodness—at last school was out. Maybe

(Continued on page 411)

Miss Voge is city nurse in Marinette, Wisconsin.

The Nurse and the Family Spirit

By ALICE BURKHARDT

ANY GOOD public health nurse would be shocked if upon visiting a home she should find that the family had not been fed for a week because Mother had been "too busy." Yet few of us stop to think twice when mothers tell us that they have "no time" to have fun with their families. Helping families to work and play happily together is one of the ways of developing close family ties which are as basic to health as is good food. Therefore this should be as important an aspect of health supervision as is the teaching of good nutrition.

In the old days home was the center of interest. Families grew their own food, made their own clothes, furniture, and fun. Through cooperative participation in and sharing of fun and responsibility, members of a family not only early learned the skills essential to the smooth running of a household, but in the process grew to know how to live with and enjoy one another. Traditional ways of doing things were passed down from one generation to another. Through cooperative and creative living a family spirit arose which made for security and stability.

Today home is often only a place in which to eat and sleep. The members of the family are virtually strangers. Because there is nothing to come home to, both children and adults vainly seek satisfaction on the streets, in lunchrooms, in taverns, and at the movies. This has made for insecurity and instability. Much of the loneliness, boredom, psychosomatic illness, and juvenile delinquency which we see and hear so much about these days has its roots in a lack of creative social living.

Public health nurses who work so closely and so skillfully with families have an unusual opportunity to help mothers to revitalize or create a family spirit.

Many of the young mothers that we meet look upon the coming of the family as a burden to bear. They are like the "old woman in the shoe"—not that they have so many children, but they don't know what to do.

Having had little experience in the arts of homemaking previous to marriage they are overwhelmed by the everyday tasks of shopping, mending, cooking, and cleaning. They either do not know how to organize well or have not had enough practice to make these jobs routine before the babies begin to arrive. Mother is "nervous" partly because of this and partly because with inadequate housing the youngsters are apt to be constantly underfoot. Many times she feels flustered and frustrated because the toddler, who is just learning to get around, is "exploring" the possibilities of her best ornaments, is pulling things out of drawers, or is climbing and bouncing on furniture in the rooms she has tried so hard to make attractive and keep clean. You will be of great help if you suggest to her that this initial "strain on the family tie" might be eased if she would plan a schedule so that the child will learn to know what to expect. This schedule should include times when each of them do things alone as well as times when they do things together.

If Mother is to expect Junior to play by himself while she gets her work done,

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she will want to see that he has a space of his very own. This may mean a revolutionary rearrangement of furniture—such as turning an infrequently used "front room" into a play room—or it may mean blocking off space with chairs in one of the other rooms. This play space, however small, should have shelves or orange crates to house the manipulative toys and materials for imitative play which Junior will use when he is alone.

If you and Mother do not know what Junior's play needs are at the various stages in the preschool years, send quickly for such pamphlets as "Some Educational Activities for the Young Child in the Home" and "Toys in Wartime."* These pamphlets cost only a few cents and have helpful suggestions on how to construct homemade play materials.

While you are explaining Junior's needs to Mother you will arouse her interest if you actually make a milk carton train like this

or if you quickly devise a manipulative toy by cutting three holes (round, triangular, and square) in the top of a shoebox (or any old box) through which corks, spools, and odds and ends of junk may be dropped. Don't let Mother get so fascinated that she doesn't hear you when you point out that she should plan each day to take Junior to the park or playground, if there is no yard, so that he will have a chance to push, pull, climb, jump, and otherwise use his large muscles. This outdoor exercise is not only essential for Junior's growth but will also cut down the wear and tear on furniture and adult nerves. Mother can "kill two birds with one stone" if she will take along her knitting or darning—or if she can plan to shop on the way home. By the way, shopping can be an educational experience and a basis for dramatic play for Junior if Mother will take time to point out the various things in the store, will introduce him to the groceryman, and will let him pay for and carry home the loaf of bread. Even at this early age he will feel that he is helping.

It takes a lot of character and forbearance many times to let little children help, but helping is fundamental to the feeling of "belonging" and being needed. A toddler can shell peas or break up beans. When he is a little older he will love to set the table and can be trusted to dry some of the dishes. Most little children like to be near Mother while she is working. They love to have a little piece of dough to make a "pie" while she is baking. Or on a hot day they immensely enjoy sailing boats (milk bottle tops) in the dishpan while she is doing the washing.

We forget sometimes that city children do not have the mud, sand, sticks and stones, and the other creative materials with which we used to play. You might suggest to Mother that, as a substitute, she can let her offspring shovel beans from one pan to another with a large spoon—or build with potatoes. You might also give her the recipes for homemade clay and finger paint.

CLAY

1 cup flour
½ cup salt
1 tsp. powdered alum
Water
Vegetable coloring (beet juice, blueing)

Mix dry ingredients. Add water and coloring. Knead.

This clay will remain pliable many days if kept in a moist cloth when it is not being used.

FINGER PAINT

6 tablespoons starch
1 qt. boiling water
Coloring

Mix starch with a little cold water. Pour mixture very slowly into boiling water. Stir until mixture thickens. Add color.

Use paint on wet shelf paper (shiny side up). Paint with fingers and hands.

These mediums, it is true, are messy and require supervision, but they are wonderful materials for Junior and Mother to play with in the times that they plan to

* Hansen, Rowna. Some Educational Activities for the Young Child in the Home. U. S. Office of Education, Pamphlet No. 51, 1934. Government Printing Office, Washington, D.C.

Toys in Wartime. Children's Bureau, U. S. Department of Labor, 1942. Free.

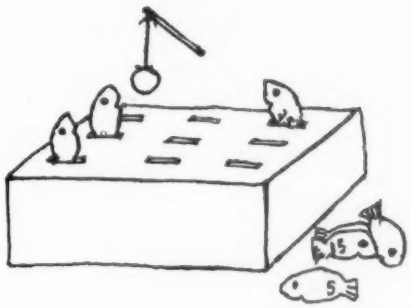
be together. Incidentally, Mother will be surprised to find that she can make attractive designs with finger paint which can later be used to decorate wastebaskets, lampshades, and the like.

At other times when they are together Mother and Junior will want to say rhymes, do finger plays, and sing. Most mothers know many songs and little children readily pick them up. Rhythm and repetition are characteristics of children's play in the preschool years. They love to beat time to radio music on a drum (box or chopping bowl and spoon). Any mother can look at a picture book, play hide-and-seek, or have an imaginary tea party with a small boy or girl, but you may have to remind her to do it.

From three years on, the preschoolers like to play singing games like "Mulberry Bush," "Looby Lou," and "Did you ever see a Lassie," and they enjoy singing and going through the motions when there are only two players instead of the usual group.

Fours, Fives, and Sixes (Sevens to Tens too) love to fish. You will delight them if you will demonstrate how to make a fishpond game that even Daddy will enjoy playing when he comes home.

Get Mother to assemble an old cardboard box or two, a piece of string, a pencil, and the wire off the milk bottle. Draw on one of the boxes four or five reasonable facsimiles of a fish. Let Mother and the five-year-old cut the fish out, and while they are doing it you can take the other half of the box and cut slits in the top long enough for the fish to stand in. Twist the wire into a circle and tie it to the pencil for a fish pole. When the fish are cut out, mark numbers from one to five on their tails and stand them up in the "sea." Now let each take a turn to see if he can catch a fish. Successful fishermen keep their fish, but unsuccessful ones have to put theirs back into the "sea." When all the fish have been caught, add up the number of pounds of fish (numbers on the tail) that each fisherman has caught. The children will want to crayon the fish and the "sea" after you have gone.



Daddy and the children especially like target games. You can suggest to Mother that she get Daddy to make a bean bag target out of a small cardboard carton by cutting a hole in one of the sides (about three or four inches in diameter). The whole family will have fun trying to toss a pair of rolled up socks into the hole (if a bean bag isn't handy). One point should be scored for each "direct hit."

Newspaper scrunched up makes a nice ball which can be thrown into the air or around the room with no danger to furniture or bric-a-brac. These newspaper balls are easy for little ones to catch and many games can be played with them. Try making some of these balls on your next visit. Give them to Mother and the children and let them try to toss them onto another sheet of newspaper which you will place a few feet away on the floor.

If you once get them started, Mother and Dad will think of many things which they can do to have fun with their preschoolers before they are kissed and tucked into bed.

Some parents seem to think that when a child reaches school age, he can pretty well fend for himself. We know that the older child is just as much in need of love and affection and the feeling of belonging as the preschooler. Under economic pressure some mothers must tie the door key around the older child's neck and go off to work. These children have no one to come home to, so they spend their after-school hours reading comic books, playing on the street, listening to the radio, or going to movies day after day. The children of mothers who are at home seem to spend their time the same way.

Radio Advertisement Strikes Keynote Here—Mother *Is* Tired, Nervous, Overworked

We do not often see the working mother, but we do see other mothers and we will want to demonstrate for them some of the things that families can do together that are creative and social.

In most families everyone comes home for supper, but in lots of homes we find that families do not sit down to eat together. It is important that they do. Mother's presence at the dinner table lends stability to the family group and you can help her to plan suppers that will enable her to keep seated. In some families mealtime is anything but pleasant, because family skeletons have a way of creeping out of closets for an airing. Mother can serve up fun with the meal if she has at her fingertips some simple games, riddles, or jokes with which to start off conversation.

Just before Mother gets ready to clear the table and serve the dessert she might start the gang clapping out and guessing rhythms of familiar songs. You know, from your own childhood, many of the guessing games like imaginary hide-and-seek and 3/3 of a ghost, which you could suggest. Lots of these can be played while the family washes the dishes together. Dishwashing doesn't really have to be a chore, but can be a social time. This is the time, too, to whistle and sing rounds.

There is a feeling of homeliness and warmth about a kitchen and it is the logical place for after-dinner fun. If it isn't attractive the members of the family will have a glorious experience "redecorating." Water paints for inside walls are cheap and foolproof and will brighten up the drabbest rooms. Attractive pictures can be found in almost any magazine that can be cut out and pasted around the wall to make an interesting border. Burlap potato sacks with gay designs cut from scraps of material appliqued on with odds and ends of yarn make unusual curtains and are fun to do when the family design and execute them together as in "Sewing Bee."

There are all kinds of table and board games that are fun to play around the kitchen table. Anagrams, jackstraws, dominoes, Chinese checkers, and card games like Rummy, Hearts, Go Fish are probably some of the many that you already know. Here is a favorite called *Scat* which you can quickly demonstrate on a visit. Cut several thicknesses of newspaper into strips about two inches wide and five inches long. Roll these strips into cylinders and tie with string leaving a tail about six inches long. These are the "Rats." Make enough rats for all but one member of the family. That member of the family is the "cat." The cat should have a penny in a small box lid or jar top. In the center of the table, place a piece of newspaper about 5″ by 5″. This is the cheese. All players except the cat put their rats onto the cheese but hold tightly to the rat tails. The cat shakes up the penny in the box lid and then puts the lid on the table open side down. He slowly removes the lid—if "heads" on the penny is uppermost the cat tries to catch a rat by covering it with the box lid. The rats of course must be jerked away. If "tails" turns up no one must budge. The cat keeps shaking up the penny until he catches a rat . . . at which point the rat caught becomes the cat. If these directions are not clear, you can find this game described under the name of "Cork Dice" in *Games for Quiet Hours and Small Spaces* (National Recreation Association).

Everyone loves dramatics and Mother will do well to save a few old clothes and some jewelry for a "costume box." You can suggest to her that on some rainy night she divide the family into sides and let each side think up and act out song titles or nursery rhymes, or some familiar story. Paper bag puppets, too, are loads of fun . . . if paper bags are available. Mother will need to lay out on the kitchen table paper bags, crayons, scissors, flour and water paste, some old magazines, or colored paper. Tell her to give the members of the family 10 or 20 minutes to make a "head" (animal, bird, person—anything). When the heads are made

Calm and Order Are Restored in Atmosphere of Singing Games—Everyone is Happy

each person in turn holds up his creation and asks the others what they think it is. Maybe they decide that one is a witch, another a rabbit, and another a little girl. They then decide what kinds of personalities these heads have. Are they sad, silly, bored, et cetera? Then why are they that way? A little plot begins to evolve. When the plot is well formulated, the actors put on the "play" by holding the heads behind the sofa or behind backs of chairs, and talking for them.

Don't forget music. The musical comb is still a good instrument. Silverware and pots and pans can be pressed into service for a family rhythm band which will give out enough jolly noise, no doubt, to attract neighbors who will want to join in when they find out that it isn't a fight but just the family having fun together.

We could go on and on with all kinds of suggestions, but by this time you must have thought of many things yourself that you can demonstrate. If not, you might try looking into some of the following books:

Boyd, Neva L. Schoolroom Games. H. T. Fitzsimons Company, Chicago, 1919. 35 cents.

——. Handbook of Games. Revised edition 1943. 1919 West Cullerton Street, Chicago.

Coleman, Mrs. Satis N. Creative Music in the Home. John Day Company, New York, 1927. $3.50.

Fisher, Dorothy Canfield. On a Rainy Day. National Recreation Association, 315 Fourth Avenue, New York, 1938. 50 cents.

Gardner, Ella. Handbook for Recreation Leaders. Children's Bureau Publication No. 231. U. S. Department of Labor, Washington, D.C., 1936. 20 cents.

Ickis, Marguerite. Home Again. Mimeographed Publication No. MP321. National Recreation Association, New York, 1942. 15 cents.

Lambert, Mrs. Clara. School's Out. Harper and Brothers, New York, 1944. $2.50.

Mapes, Mary A. Fun with Your Child. Howell, Soskin, New York, 1943. $2.50.

Mason, Arthur, and Mitchell, E. D. Social Games for Recreation. A. S. Barnes and Company, New York, 1935. $2.50.

Musselman, Virginia. Home Play in Wartime. National Recreation Association, New York, 1942. 10 cents.

National Recreation Association. Games for Quiet Hours and Small Spaces. The Association, New York, 1938. 50 cents.

——. Singing America. (Edited by Augustus Zanzig.) C. C. Birchard and Company, Boston, 1940. 25 cents.

The important thing is to get into action. If you do, you will be sowing the seeds for a happier life for the families you work with, and you will establish a new bond in the nurse-patient relationship that will prove to be of inestimable value in the months to come.

Nurse Placement Service

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom, consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Mrs. Marguerite L. Hays, B.S., M.A., secretary, health council, Council of Social Agencies, Dallas, Tex.

Mrs. Astrid Johnson, A.B., industrial nurse, Vaughn Novelty Company, Chicago, Ill.

Eleanor J. Weinsheim, camp nurse, Clearwater Camp, Minoqua, Wis.

ASSISTED PLACEMENTS

*Margaret L. Shetland, B.S., M.A., p.h.n. consultant, Michigan State Department of Health, Lansing, Mich.

*Violet L. Sobers, B.S., assistant nurse officer, United Nations Relief and Rehabilitation Administration, Washington, D.C.

*Mrs. Mary R. Caron, B.S., M.A., special nursing field representative in Red Cross home nursing, American Red Cross, Eastern Area, Alexandria, Va.

*The NOPHN files show this nurse is a member.

Transferring a Red Cross Nursing Service

By MRS. DORIS RHEA, R.N.

ALEXANDRIA, Virginia, a city of great historical importance in the United States, was one of the first to participate in the American Red Cross Public Health Nursing Service. In 1916, a public health program was organized by the Alexandria Red Cross Chapter, which continued to 1924 when it was taken over as a joint program with the local tuberculosis association. This cooperative effort included not only health education and bedside care, but tuberculosis and orthopedic clinics as well.

By 1936, when the population had increased from 18,000 to 30,000 residents, the city health department had developed sufficiently to take care of the clinical and preventive program, the tuberculosis association withdrew to carry on its own program. The local Red Cross chapter assumed sole responsibility for administration and financial support of a bedside care service. During the next four years, this chapter program was increasingly identified as an integral part of the community health services. A well qualified nurse and an active chapter committee, cooperating with other health agencies, laid a sound foundation for the subsequent development of the visiting nurse association.

From a quiet residential community, rich in historic associations, Alexandria, in wartime, was growing into an industrial center. By 1942 the population exceeded 50,000. The Naval Torpedo Plant, built during World War I, was reopened, providing employment for hundreds of men and women who moved in from surrounding communities. An overflow of the increased population in the nearby nation's capital further taxed housing and health facilities. Housing projects were developed to provide living quarters for thousands of new families, and the local 100-bed hospital, finding itself unprepared to meet the emergency, secured federal funds to erect a new wing. The health department added nurses to its staff, and the tuberculosis association supplemented its clinical facilities to provide for the health problem which was increasing under the crowded living conditions.

Along with other health agencies, the Alexandria Red Cross Chapter was finding it difficult to meet the demands placed upon its nursing service. The chapter nursing committee recognized that, in order to meet these needs, an adequately staffed visiting nurse service was necessary. Since the beginning of the American Red Cross public health nursing program, its purpose has been to encourage the development of chapter public health nursing programs for the purpose of demonstrating the value of these services and assuring their maintenance by an ultimate transfer to private or to public tax-supported agencies.

In this case enlargement of the local health department nursing program to include bedside care was a possible development. This alternative was discussed. It was impractical to make this arrangement at the time for the reason that the local health department was understaffed and unable to assume additional nursing duties over and above those basically required. After conferences with local and state health department officials it was decided that plans for a bedside service by a Virginia health department would have to be deferred until after the war.

The Washington visiting nurse association geographically was impractical as

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a possible source of bedside nursing service in Alexandria. The distance between the two communities is between 7 and 10 miles. Too, the State of Virginia and the District of Columbia maintain separate health departments and it would be very confusing to plan for service in Alexandria through such detailed health administration. The Metropolitan Life Insurance Company was giving home nursing care to its policyholders.

After completing a careful study of existing community health services and needs, the chapter nursing committee submitted its proposal for the establishment of a visiting nurse service to the Alexandria Council of Social Agencies. The Council had been active for many years in coordinating the programs of health, welfare, and recreation agencies, and in assuming responsibility for the establishment of new agencies of this kind. The initial discussion of this matter with the Council resulted in the appointment of a subcommittee, to be known as the Alexandria Health Committee, whose function was to assist in making a complete survey of community health services and needs, and to make recommendations to the Council for the further coordination of the services.

The first meeting of the Alexandria Health Committee was held on March 31, 1943. The committee included a representative from each of the following agencies:

Community Medical Society
Health Department
Health Center
Family Service Society
Tuberculosis Association
Community Chest
Local Chapter of American Red Cross
Metropolitan Life Insurance Company
Local Hospital
Chairman and Secretary of the Council of Social Agencies
Ministerial Association
Department of Labor
City Government
Eastern Area Nursing Service, ARC
Department of Education

This meeting was conducted as a forum, with each representative giving a brief description of the activities of his agency in relation to the expressed need for a visiting nurse organization in the community. It was recognized that the development of this service depended on:

1. Careful study of community health services to determine need
2. Approach to Community Chest to secure funds
3. Appointment of a board of directors to be given responsibility for the development of this service

It was also pointed out that Alexandria was no longer a closely knit community, that many individuals had neither friends nor family to call upon them when they were ill, and many families were in need of more adequate health education and protection. Mortality rates pointed to the need for an adequate nursing staff to give instruction in maternal and child hygiene. Because of overcrowded conditions in the hospital, cases dismissed early needed postpartum and postoperative care in their homes. The tuberculosis association reported a marked increase in tuberculosis together with a decrease in sanitarium facilities. The Red Cross representative, describing a heavy load, reported that the pay service of the chapter program had increased with the general trend toward higher incomes, and that adequate visiting nurse service with supplemental assistance from the Community Chest could be operated on a partially self-supporting basis.

The meeting concluded with the motion, unanimously passed, that *"the Health Committee present a summary of the findings of this group to the next Council of Social Agencies meeting, recommending that they 'take steps to establish a visiting nurse organization in Alexandria.'"*

Following is a summary of this first report presented to the Council:

> The formation of a visiting nurse association to be incorporated under the laws of Virginia by a board of approximately fifteen members as a nonprofit corporation. That this board of directors consist of professional and lay members to be appointed by the Health Committee.
>
> That this nursing service be initiated with a supervisor who shall have a degree in public health nursing and supervisory experience, with four staff nurses who shall have necessary experience and training to qualify under the standards recommended by the National Organization for Public Health Nursing or who shall have completed one year of supervised experi-

ence in a recognized nursing agency. That if for sufficient reason, personnel with these qualifications are not available, nurses with lesser qualifications be employed on a temporary basis. That necessary secretarial assistance be provided.

That salaries of the staff be established at rates prevailing in this area for similar positions and that transportation and other necessary operation expenses be provided for. These costs are estimated to aggregate $12,500 per year for the proposed organization.

That this staff be considered the minimum feasible under present limitations on availability of qualified personnel, and the service be expanded as conditions permit.

That income to maintain this service be acquired from the following four sources:

1. Nursing fees from patients able to pay in full or in part
2. Contracts with insurance companies and industries to provide nursing service (on a fee basis) to their policyholders and employees
3. Donations from individuals and organizations to allow for initial investment in necessary equipment and to provide for special needs and expenses
4. Affiliation with the Community Chest to secure compensation on a purchase of service basis for sick patients whose bedside nursing care must be subsidized in full or in part

Therefore, the Health Committee proposed the following resolution:

BE IT RESOLVED: That the Alexandria Council of Social Agencies approve the organization of a visiting nurse service.

These recommendations were approved by the Council, and the Community Chest agreed to include a visiting nurse association program in its 1943 budget.

By this time public interest in the project was growing. A meeting of citizens was held in the Virginia Public Service Company's auditorium, at which the director of Red Cross Eastern Area Nursing Service explained the functions and operation of a visiting nurse association. The budget subcommittee prepared letters to individuals in the community, asking for initial financial gifts to provide the necessary capital outlay for the program. Other subcommittees assumed their responsibilities for public information and plans for personnel. It was decided that this new program should be ready to operate in Alexandria as of January 1, 1944. The remaining months of 1943 saw great activity among the members of the Council of Social Agencies, the Alexandria Health Committee, the Red Cross chapter board, and other groups interested in the promotion of better health in the city.

Approximately 15 months were spent in the development of the new Visiting Nurse Service, Inc., in Alexandria, the offspring of the local Red Cross chapter, whose nursing activities committee provided the initial impetus. The representative membership and functions of the Council of Social Agencies in the community provided the nucleus for the development of this visiting nurse service.

Briefly the following steps were taken in the transfer of the Alexandria program:

1. Motivation by Alexandria Red Cross chapter representatives
2. Discussion of project with executive secretary and committee of the Council of Social Agencies
3. Development of the Health Committee to survey community health services and determine needs
4. Presentation of need and suggested program to Council of Social Agencies
5. Approval of Council of Social Agencies
6. Approval of Community Chest for financial support
7. Appointment of visiting nurse service board of directors to set up personnel requirements and practices, standards, and details of program content
8. Action of this board to incorporate the association as required by Virginia law
9. Further coordination of community nursing services by consideration of contract with Metropolitan Life Insurance Company, following establishment of the visiting nurse program

With a qualified supervisor and a four-nurse staff, the Visiting Nurse Service, Inc., now serves a community of 65,000 residents. Through a contract with MLI, it handles all insurance health visits, thus eliminating one nursing agency. Coordination of local services has been very well worked out, with the health department, tuberculosis association, local hospital, and physicians as the chief sources of case referrals. Inter-agency reports are prepared regularly and the staffs of the private and public agencies work very closely toward the objective of providing better health service and education to the com-

munity. Through the farsighted planning of those who initiated the program, the Visiting Nurse Service is set up according to the best public health standards and is conducted to meet the needs of a busy and growing community. It has become, in its few months of existence, a vital part of the life of Alexandria.

When Polio Strikes . . . Helpful Hints for Everyone

JUNE through September is the season when infantile paralysis generally is on the upswing in the United States. The National Foundation for Infantile Paralysis has compiled the following suggestions which will be helpful to residents of areas where poliomyelitis is on the march.

1. During an outbreak of infantile paralysis be alert to any early signs of illness or changes in normal state of health, especially in children. Do not assume that a stomach upset with vomiting, constipation, diarrhea, severe headache or signs of a cold and fever are of no importance. These may be among the first symptoms of infantile paralysis. All children and adults sick with unexplained fever should be put to bed and isolated pending medical diagnosis.

2. Don't delay calling a physician. Expert medical care given early may prevent many of the crippling deformities. Proper care from the onset may mean the difference between a life of crippling and good recovery.

3. Today there is no known prevention or protection against infantile paralysis. All that can be done is to provide the best possible care. Your doctor, your health officer, and your local chapter of The National Foundation for Infantile Paralysis can and will do everything in their power to see to it that your community is ready to meet an epidemic.

4. Observe these simple precautions:

(a) Avoid overtiring and extreme fatigue from strenuous exercise.

(b) Avoid sudden chilling such as would come from a plunge into extremely cold water on a very hot day.

(c) Pay careful attention to personal cleanliness, such as thorough hand-washing before eating. Hygienic habits should always be observed.

(d) If possible avoid tonsil and adenoid operations during epidemics. Careful study has shown that such operations, when done during an epidemic, tend to increase the danger of contracting infantile paralysis in its most serious form.

(e) Use the purest milk and water you can. Keep flies away from food. While the exact means of spread of the disease is not known, contaminated water and milk are always dangerous and flies have repeatedly been shown to carry the infantile paralysis virus.

(f) Do not swim in polluted water.

(g) Maintain community sanitation at a high level at all times.

(h) Avoid all unnecessary contact with persons with any illness suspicious of infantile paralysis.

5. Don't become hysterical if cases do occur in your neighborhood. While infantile paralysis is communicable or catching during any outbreak, there are many who have such a slight infection that there are few or no symptoms. This large number of unrecognized infections is one of the reasons there is no practical way of preventing the spread of the disease. But it is also reassuring to know that, of the many persons who become infected, few develop serious illness and that, with good care, the majority who are stricken will make a satisfactory recovery. Remember that although this is a frightful disease, needless fear and panic only cause more trouble.

6. Attempts to stop the spread of the virus by closing all places where people congregate have been uniformly unsuccessful. The resulting disturbance to community life is a disadvantage. Today there is no way by which the spread of infantile paralysis can be completely stopped.

7. There is no known cure for infantile paralysis. Good medical care will prevent or correct some deformities. But in about every fourth or fifth case there will be permanent paralysis that cannot be overcome. Do not believe those who for one reason or another promise to cure these cases. Be guided by sound medical advice if polio does strike.

8. County chapters of The National Foundation for Infantile Paralysis are prepared to work with health officers, doctors, nurses, physical therapists, hospitals and patients. These chapters stand ready to use their funds to assist the entire community. Know your chapter—ask its help if needed—and volunteer to help your chapter so that it will be able to render the necessary services.

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"Unaccustomed As You Are . . ."

By LILLIAN M. O'CONNOR

MANY of you in the various phases of nursing, especially those in the field of public health nursing, are sometimes haunted by that board meeting, or community group meeting, or annual conclave of your administrators or parent-organization at which the main event is to be the talk given by—YOU! Designate the meeting what you will—conference, assemblage, or just plain "clambake," it will be no picnic for you until you get that talk prepared. Of course, you know the main points which you expect to present. In all likelihood, it's that special report on your particular day-to-day job and what has been accomplished since you last reported. In public speaking parlance you will be giving a "speech to inform" since your chief purpose is to give your hearers information. Every item you use you will weigh, and choose or discard, in relation to this particular audience and how it will aid the audience to understand your work.

So far, so good. But how to begin? How does a speaker get to this fine material? An analysis of many speeches reveals that a good talk is made up of three distinct parts: the introduction, the main discussion, the conclusion. The main discussion is, of course, made up of the material mentioned above. It is the meat, the information, the intellectual content. And it presents the least difficulty to an adult speaking upon a topic which springs from her main work or interest.

The introduction, on the other hand, presents difficulties to the new speaker who has not had an opportunity to study functions and possible techniques. First, the introduction should render the hearer amiable toward the speaker; second, attentive to her words; and third, amenable to the instruction or information. Every word must help to do these three things. Begin by addressing the presiding officer "Mr." or "Madame Chairman," and follow this with a salutation of each guest who is distinctive by reason of office, rank, or present importance in the group, as well as the group as a whole. Sometimes the salutation grows lengthy, but this is your first bid for attention from the group and your familiarity with their various guests and groups will be noted with approval. When you are actually delivering the salutation, take time to look in the direction of the person named. This will give your audience time to get settled; it will cushion your shock at that "sea of faces." A pattern which may aid you is as follows: Mr. Chairman (or Mr. President, if that is the case), members of the board of directors, representatives of the safety council, members of the public health staff, ladies and gentlemen. Variations will be many of course.

What you say after the salutation depends upon the *purpose* of your talk, and upon the *spirit* of the meeting. You may be serious, dignified, humorous, conversational, whatever is most fitting for the occasion. Decide which manner will be in keeping with the occasion, and then use one of the following for your opening remarks:

a. A narrative, timely and apt, drawn probably from your daily experience in caring for the community health. This is good because it leads directly into your main discussion or report. (NOTE: Do not make the mistake some speakers make of thinking that the narrative must be funny. If a humorous anecdote does not lead into your topic, discard it, or rather, file it away for another occasion.)

b. A proverb or statement well known to the group. Familiar words bring interest and help

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to focus attention upon the speaker and her message.

c. A quotation from an outstanding authority in the field or—and this might be a great deal better in some groups—a quotation from a familiar community figure, or from one of the officers of the group.

d. A statement which arises out of the occasion itself, or from the circumstances of the gathering.

e. A reference to the talk of a speaker who has preceded you on the program.

Whatever you use, be sure to relate it to the topic so that the introduction actually introduces. The five suggestions listed above should give you enough variety until, through experience, you find your own favorite way, and the one which brings you best results from your audience.

The other day I sat at a meeting of women prominent in the radio industry: program directors, managers of stations, some with their own programs on a national hookup. One of the speakers was Mrs. Eleanor Stevenson, the writer, who had just returned from many months on the European battlefront. After the salutation of the chairman, the members of the panel, the association members, and their guests, Mrs. Stevenson began her talk with a little narrative about a soldier from the State of Mississippi.

"Where you from?" he was asked in Britain.
"Mississippi," was his reply.
"You're a long way from home, son!"
"Ah was a long way from home when Ah was in Hoboken!" was the American's reply.

This anecdote was followed by one from Mrs. Stevenson's own experience in London, and then one from her time spent at the actual battlefront. Notice the skill in the choice of locale of each bit of America in Europe: progression by easy stages which took us away from a conference room in New York and right up to the front lines where the speaker wanted us to be and to see the American soldier today.

Some day before that talk of yours becomes history take time to look up the magazine, *Vital Speeches*, a bimonthly publication which contains copies of contemporary speeches of significance. Study the introduction in relation to the situation as given. Analyze some to find out which of the methods mentioned here are being used by modern speakers. List other ways of beginning not referred to here. You'll find that some speakers merely state the purpose and plunge immediately into the discussion. Study the situation to discover why this method was used and thus learn when you might try it. Just in passing, let me say that the radio address is not the same at all as the face-to-face audience situation. The exigencies of radio are enormously different from direct public speaking, and so must be the method and material and style of preparation and delivery.

Sometimes it is appropriate to acknowledge the introduction given to you and your topic by the presiding officer. If you feel this to be the case, fit in your thanks after the salutation. If the chairman has praised you and that "highly, not to speak it profanely," do not deprecate *your own worth in your own field*. Nurses are prone to undervalue their own abilities. Distinguish between praise and flattery. An expert in your own field, study the principles of organization and speaking, and let the chairman's introduction stand, with this special observance, "that it o'erstep not the modesty of nature."

One of the finest examples of appropriate introduction to the topic grew out of the circumstances of the gathering, device (d) above. It consisted of one sentence and was used many years ago by Mrs. Ruth Bryan Owen (later Rohde), daughter of William Jennings Bryan who, as you recollect, was a perennial candidate for various offices including that of President of the United States. He always ran on a temperance platform. Mrs. Owen was appearing as a lecturer on a Chautauqua circuit which embraced our small midwestern town. Her talk was scheduled for the evening on this particular occasion. All that day it had rained heavily, and, even though it had cleared off into one of those beautiful soft evenings familiar to the rolling prairies of the middle Mississippi Valley, everything was soaking wet: the Chautauqua tent, the seats, the platform. But the crowd arrived to hear the daughter of Bryan. As

we stood—the seats were too damp to sit on—Mrs. Owen stepped out gingerly in front of us, looked down at us, smiled graciously and said,

"Ladies and Gentlemen, this is probably the first time any member of my family ever appeared on a wet platform."

With that friendly greeting and her warm manner, she had won us all; flattered us no doubt, small towners that we were, by that disarming statement. It made us important because, by her statement, we knew all about her family and its national prestige. That "wet platform" was equal to the "flowing tide" of Maggie Shand in Sir James Barrie's play, "What Every Woman Knows."

And the straightforward acceptance of August weather delighted us.

Look for such simple things. They are inherent in every situation involving speaker, audience, and communication. The alert nurse will find many and will turn them to the advantage of her work.

Tale of a Bag

(Continued from page 398)

now I would be on a merry run. My mistress was happy, too, because she had arranged to divide her time more fairly between school work and other phases of what she calls "generalized service." My, but that sounded like a big job. I wondered if I would help. I had a gay summer—you could almost call it a "baby summer" for I saw ever so many new babies, many whose fathers were out fighting to give their little ones a chance to live in a free country. Much of the stiffness was taken out of me, for I was getting to move more and more. Each time I was opened I could stretch and gaze around. My books were given out and my supplies used daily to help bathe babies, check their temperatures, and check their weight. Imagine, I even carried a little "ragman" scale! Yes, I was as happy as could be, for I had seen many homes in Marinette and each one was different in some way. I would get cleaned and receive new supplies almost every week. Sometimes I was so nice and full my belt could hardly be hooked.

Ah, I almost forgot—

There was one day when my mistress was real busy bathing a little whippersnapper—let me see—guess she called it a Pre-Ma-Ture. I thought for sure she would forget little Butch sitting like an outcast but, thank goodness, she didn't. She had him sit with his Mommie and watch everything and when she was all through, she took two sticks—tongue blades, I soon learned,—and made him an aeroplane. Why, he was proud as punch that the new baby didn't get all the attention.

Once I got to see somethin' different than babies. It was a hot, miserable day in August and I was plenty hot sitting in that stuffy car. I was spoiled and I wanted to get out. Well, I did and imagine my surprise when I sat on a table and peeked at a poor old lady lying in bed hot and miserable, and I guess she was even in pain. Why, I cooled off just watching her get a sponge bath. When I got back to the car I felt like a new bag. The lady was happy and comfortable, I had my fling, but then, I looked—my "boss" was hot and tired and I couldn't do a thing!

Ten years from now I may begin to look old and be stiff from old age, but I'll still be good and I'll be proud. Why, many of my little clients will be in school, healthy and happy. Maybe I helped to make them this way. I hope I did. At least I have given my services to the city. They bought me (and I dare say I was pretty expensive) and they took good care of me. Maybe I wasn't used a great deal during the first year, but I knew next year would be a busy one. Only today I heard the nurse arranging her school program so that I would get around more during the next year. I'll be her best partner and between the two of us we'll do our best to keep our people healthy while so many men are fighting for us. We owe it to them.

My story may not be very good and my English may be poor, but you see I'm only seven months old, but—*I* do get around.

Nursing Care in Prepayment Medical Care Organizations

By MARGARET C. KLEM

NURSING associations throughout the United States are not only concerned with methods of providing adequate nursing services during the present emergency, but are also carefully studying the outlook for professional nurses in the postwar era. Developments in all fields of medical care are being followed with much interest. Important action indicating the trend of opinion within the nursing profession regarding health insurance was taken in June 1944 when the Joint Board of the National Organization for Public Health Nursing, the American Nurses' Association, and the National League of Nursing Education, went on record as favoring "the expansion of prepayment health insurance plans with the provision for nursing service, including nursing care in the home."[1]

That local as well as national associations are following present trends in health insurance with interest and are voicing their desire to participate is evidenced by action taken in California and in New York City where health insurance proposals have assumed major importance within the past year. In California, the executive director of the State Nurses' Association declared that members of the Association believed that a health insurance plan should furnish nursing services when the services are deemed necessary by the physician in charge and that the association was prepared to offer an amendment to any health insurance bill coming before the California legislature to provide for such services. The director declared further that the nursing profession should have a place on the board of the proposed health service authority or on the executive body of any other approved system.[2] In New York, while discussing Mayor LaGuardia's health insurance plan for Greater New York, the executive director of the Visiting Nurse Service of New York, in an address before the New York Counties Registered Nurse Association, similarly expressed the hope that nursing services would be included in the New York Health Insurance Plan and suggested that professional nurses consider the value of such inclusion and look toward representation on the board of directors.[3]

Interest by the nursing profession in the provision of nursing services through insurance is not new. Studies of health insurance have been made by NOPHN and ANA committees at regular intervals for many years. Actually, nursing care has been provided through insurance since 1909 when the initial experiment was made by the Metropolitan Life Insurance Company. More than 70 companies now offering health and accident policies issue a variety of policies which provide some type of nursing service.[4] There are also in operation in the United States more than 200 prepayment medical care organizations of which nearly half regularly employ registered professional nurses as members of their staffs. Approximately 45 percent of the 5 million persons eligible for medical care through association with these organizations are entitled to receive the services of either special nurses or visiting nurses or both,

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and more than 2,000 registered professional nurses are regularly employed members of the staffs of these prepayment organizations which offer nursing services.

SURVEY OF PREPAYMENT MEDICAL CARE

In 1943 the Bureau of Research and Statistics of the Social Security Board prepared a digest of information received during the spring of that year from 214 prepayment medical care organizations. A new study, based on information received in January-May 1945 will soon be published.[5] Nearly all organizations which furnished data for 1943 are included in the 1945 digest which also contains information on prepayment medical care organizations established since 1943. In the following pages information on nursing services received from the 229 organizations supplying data in 1945 is compared with similar data for 214 organizations in 1943. Organizations furnishing information have been classified by type as follows: industrial, medical society, private group clinic, consumer-sponsored, and government.

Prepayment plans associated with industrial establishments are more numerous and their membership is larger than those of any other type. These plans are financed in three ways: by employers, by employees, and jointly by employers and employees.

Medical society plans are those which have been organized by either state or county medical societies. Medical services in plans of this type are provided by physicians in private practice who have chosen to participate in the plan. The majority of the new organizations furnishing information in 1945 were of the medical society type.

The term private group clinic has been used to designate organizations owned and managed by one or more physicians. Services are usually provided by physicians practicing as a group.

Consumer-sponsored plans are organized and directed by subscribers. They resemble somewhat industrial plans organized and financed by employees.

Government plans have been established by a federal, county, or city governmental unit for its employees. Membership in organizations of this type is usually compulsory.

NURSES IN PREPAYMENT PLANS

In 1945, nearly half of the 229 organizations furnishing information reported that they employed registered professional nurses as full-time members of their staff. The total number of nurses employed by these 109 organizations was 2,092. A comparison with similar data received in 1943 (Table 1) shows that there has been little change in either the number of nurses employed or in their distribution by type of organization. In each year from 65 to 70 percent were employed by industrial organizations, approximately 15 percent were associated with private group clinics; consumer-sponsored plans and government plans sponsored by the War Food Administration employed from 5 to 10 percent each; while 2 percent or less were associated with medical society plans.

The majority of nurses employed by prepayment medical care organizations either perform duties corresponding to those of nurses employed by physicians in private practice or are associated with hospitals owned or controlled by the organization. A smaller number serve as visiting nurses.

A striking difference among plans appears in the extent to which nurses are members of the staff. Almost all private group clinics and industrial plans financed entirely by the employer have staff nurses. Medical society plans, which in most instances provide medical services through physicians in individual practice, reported very few nurses on their staffs in 1945. The outstanding exception is in California where the medical society plan furnishes care for residents of war-housing projects and provides the services of general practitioners and nurses through clinics established in the projects.

The 177 nurses employed by government organizations were associated with plans sponsored by the War Food Administration for seasonal farm workers recruited, transported, or placed by that

TABLE 1. NUMBER OF PREPAYMENT MEDICAL CARE ORGANIZATIONS EMPLOYING NURSES, NUMBER OF NURSES ASSOCIATED WITH EACH TYPE OF ORGANIZATION, 1945 AND 1943 [1]

[Data furnished by 229 organizations in 1945 and by 214 organizations in 1943]

Type of organization	1945					1943				
	Persons eligible for medical care	Organizations		Nurses		Persons eligible for medical care	Organizations		Nurses	
		Total number	Number employing nurses	Number	Percent		Total number	Number employing nurses	Number	Percent
Total	4,975,850	229	109	2,092	100.0	3,320,408	214	117	2,148	100.0
Industrial:										
Financed by employer	212,590	19	17	119	5.7	207,649	14	14	104	4.8
Financed jointly by employer and employee	546,772	47	33	412	19.7	583,402	53	33	507	23.6
Financed by employee	752,786	49	21	805	38.5	734,274	47	21	877	40.8
Medical society:										
Washington and Oregon	954,100	22	1	9	.4	230,147	15	0	—	—
Other States	1,640,256	31	1	22	1.0	742,320	20	1	46	2.1
Private group clinic	406,330	21	17	339	16.2	390,980	23	22	297	13.8
Consumer-sponsored:										
Financed partly by Department of Agriculture	23,553	5	—	—	—	35,587	6	4	5	.2
Other	326,561	27	13	209	10.0	152,754	24	11	190	8.8
Governmental:										
War Food Administration and cooperating agencies	97,300	6	6	177	8.5	225,500	7	7	108	5.0
Other	15,602	2	—	—	—	17,795	5	4	14	.7

[1] Data for 1945 relates to January-May; that for 1943 is largely for the spring of that year.

TABLE 2. NUMBER OF PERSONS ELIGIBLE FOR CARE UNDER PREPAYMENT MEDICAL CARE ORGANIZATIONS AND NUMBER OF NURSES ASSOCIATED WITH SUCH ORGANIZATIONS, BY CENSUS REGION 1945 AND 1943 [1]

[Data furnished by 229 organizations in 1945 and by 214 organizations in 1943]

Census region	1945				1943			
	Persons eligible for medical care		Full-time registered professional nurses		Persons eligible for medical care		Full-time registered professional nurses	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	4,975,850	100.0	2,092	100.0	3,320,408	100.0	2,148	100.0
New England	129,236	2.6	3	.1	13,097	0.4	2	.1
Middle Atlantic	685,061	13.8	142	6.8	350,729	10.6	100	4.7
East North Central	1,056,646	21.2	244	11.7	793,533	23.9	258	12.0
West North Central	376,862	7.6	185	8.8	309,910	9.3	167	7.8
South Atlantic	303,633	6.1	151	7.2	204,084	6.1	167	7.8
East South Central	277,464	5.6	114	5.5	292,287	8.8	159	7.4
West South Central	183,948	3.7	81	3.9	198,820	6.0	84	3.9
Mountain	143,907	2.9	101	4.8	115,029	3.5	123	5.7
Pacific	1,810,093	36.4	1,071	51.2	1,038,327	31.3	1,088	50.6
Hawaii	9,000	0.2	—	—	4,592	0.1	—	—

[1] Data for 1945 relates to January-May; that for 1943 is largely for the spring of that year.

agency. This figure represents the average number of nurses employed during a year, for the number varies greatly with the seasons. An annual average of 97,300 persons are eligible for medical care through these organizations. Services are provided at government expense and all members are entitled to the services of visiting nurses. Nurses associated with these WFA-sponsored organizations covering 6 areas of the country perform such duties as giving health education, organizing health clubs, making periodic sanitary inspections, holding nursing conferences, advising on nutrition, assisting at clinics held by physicians, arranging for hospitalizations when necessary, making contacts with physicians, maintaining clinics, and acting as a liaison with the local health departments and local voluntary agencies. Many of the persons eligible for services call on the nurses for treatment of minor ailments which do not need to be brought to the attention of the physician; in 1943, on the average, two visits to nurses for services of this type were made for each clinic visit to physicians.

Number of persons eligible for services and nursing staff. Approximately 5 million people were eligible for medical care in the 229 organizations furnishing information in 1945, an increase of more than 1.5 million over the number eligible for services through the 214 organizations reporting in 1943. During the interval between the two studies several new medical society plans were organized; the number providing information increased from 35 in 1943 to 53 in 1945, and the increase in membership in plans of this type was almost 1.5 million. Changes since 1943 in membership in other types of organizations are relatively insignificant when compared to this increase.

Since medical society plans rarely employ nurses, their increase in membership and the present nursing shortage probably account for the fact that nursing staffs have not grown in proportion to membership. Persons eligible for care in industrial plans decreased by 13,000 and the number of their staff nurses decreased by 152. Private group clinics increased their membership by 16,000 and the number of staff nurses by 52. Consumer-sponsored plans, excluding

those financed partly by the Department of Agriculture, more than doubled their membership but employed only 19 more nurses than in 1943. Governmental plans sponsored by the WFA averaged 97,300 members, a decrease of 138,000 persons, but they increased their nursing staff by 69 nurses.

Regional distribution. A comparison of the number and percent of nurses employed throughout the various sections of the United States shows that there has been practically no change during the past two years (Table 2). In 1945, as in 1943, 50 percent of the nurses employed by prepayment medical care organizations were associated with plans in the Pacific Coast region; 12 percent were employed by organizations in the East North Central States; other regions employed less than 9 percent each, while the New England States reported only 3 nurses.

The region in which the largest number of nurses were employed (the Pacific) also had the largest membership in prepayment medical care organizations. In this region the ratio of nurses to persons eligible for medical care was 1 to 1,700. The East North Central States, with the second largest membership as well as the second largest number of nurses, had a ratio of only 1 nurse to every 4,300 persons eligible for medical care. In most regions the ratio averaged 1 nurse to 2,000 persons.

PERSONS ELIGIBLE FOR NURSING SERVICES

In 1945 about 2.2 million persons, or 44 percent of the 5 million eligible for medical care, were entitled to receive either special duty nursing or services of visiting nurses or both—an increase of half a million over the number eligible for these services in 1943. Approximately 1.1 million or 50 percent of the persons eligible to receive these services in 1945 were associated with industrial organizations; more than 800,000 or 37 percent were eligible through medical society plans in Washington and Oregon; 7 percent through private group clinics; 5 percent through government plans sponsored by the War Food Administration; and 1 percent through consumer-sponsored plans.

A comparison of data furnished in 1945 and 1943 shows that the percentage of persons eligible for special duty nursing or services of visiting nurses or both varied to some extent when considered by type of plan (Table 3). The most noticeable increase was in medical society plans in Washington and Oregon where 85 percent of all persons eligible for care could receive one or both of these services in 1945 as compared with 75 percent in 1943. A decline occurred for government plans except for WFA-sponsored (which in 1943 agreed to provide nursing service to 16 percent of those eligible for medical care) due to the fact that in 1943 the largest number eligible for nursing services were in organizations operating in the National Park areas. These plans have been discontinued temporarily because of the war. Industrial plans financed by employees provided special duty nursing or services of visiting nurses or both to 77 percent of their subscribers and dependents in 1945 and increased the number eligible for services from 516,000 in 1943 to 577,000 in 1945.

Special duty nursing. In 1945 and in 1943 more than one third of all persons eligible for medical care were entitled to receive special duty nursing. While medical society plans in Washington and Oregon agreed to provide such services to 85 percent of their membership, those plans in other states furnished neither special nor visiting nurse's care. Industrial plans financed by employees included special duty nursing among the services available to 73 percent of those eligible for medical care; jointly financed plans made such services available to 45 percent of their membership, and employer-financed plans to 28 percent. In private group clinics 40 percent of the membership was eligible for this service. Governmental plans reported no special duty nursing. The largest increase in proportion of membership eligible for special duty nursing services was in the medical society plans in Washington and Oregon; such services were available for 75 percent of the membership in 1943 and for 85 percent in 1945.

TABLE 3. NUMBER OF PERSONS ELIGIBLE FOR MEDICAL CARE AND PERCENT ELIGIBLE FOR SPECIAL DUTY AND VISITING NURSE SERVICE IN PREPAYMENT MEDICAL CARE ORGANIZATIONS, BY TYPE OF ORGANIZATION, 1945 AND 1943[1]

[Data furnished by 229 organizations in 1945 and by 214 organizations in 1943]

Type of organization	1945					1943				
	Number of persons eligible for medical care	Percent eligible for special duty or visiting nurse service				Number of persons eligible for medical care	Percent eligible for special duty or visiting nurse service			
		Total	Special duty only	Visiting nurse only	Both special duty and visiting nurse		Total	Special duty only	Visiting nurse only	Both special duty and visiting nurse
Total	4,975,850	44.2	33.0	7.4	3.8	3,320,408	50.2	31.7	13.9	4.6
Industrial:										
Financed by employer	212,590	45.6	4.3	17.8	23.5	207,649	50.2	1.2	39.5	9.5
Financed jointly by employer and employee	546,772	77.9	45.0	32.9	—	583,402	76.1	65.7	8.2	2.2
Financed by employee	752,786	76.7	60.8	4.0	11.9	734,274	70.2	51.6	8.8	9.8
Medical society:										
Washington and Oregon	954,100	84.6	80.4	—	4.2	230,147	74.9	57.5	—	17.4
Other States	1,640,256	—	—	—	—	742,320	—	—	—	—
Private group clinic	406,330	39.6	39.6	—	—	384,965	38.9	38.9	—	—
Consumer-sponsored:										
Financed partly by Department of Agriculture	23,553	—	—	—	—	35,587	8.3	—	8.3	—
Other	326,561	9.6	—	7.3	2.3	152,754	13.5	3.0	5.7	4.8
Governmental:										
War Food Administration and cooperating agencies	97,300	100.0	—	100.0	—	225,500	100.0	—	100.0	—
Other	15,602	1.2	—	1.2	—	17,795	16.6	1.0	15.6	—

[1] Data for 1945 relates to January-May; that for 1943 is largely for the spring of that year.

The greatest decrease was in the jointly financed industrial plans; the proportion of members eligible for special duty nursing services dropped from 68 percent in 1943 to 45 percent in 1945.

Although some organizations provide special duty nursing in the home, in most cases this care is given only in the hospital. Contracts usually set no special limit to the length of time such services can be furnished. Recommendations of the physician are, of course, a standard requirement for furnishing this form of service.

Services of visiting nurses. The major change in the proportion of members eligible for one or both types of nursing service occurred in the group eligible to receive the services of a visiting nurse. In 1945, 557,000 or 11 percent of the persons eligible for medical care in prepayment organizations, were entitled to receive services by visiting nurses; in 1943, 619,000 persons or 18 percent of those eligible for medical care were entitled to this service. With the exception of consumer-sponsored plans, which made this service available to 10 percent of their membership, and medical society plans in Washington and Oregon where 4 percent may receive the service, all persons eligible for this type of care were associated with either industrial or government sponsored plans. The War Food Administration in both 1943 and 1945 included care by visiting nurses among the services available to all those eligible for medical service through its plan. Several industrial plans furnishing this care in 1943 reported that in 1945 the service had been temporarily discontinued.

VOLUME OF NURSING SERVICES AND COSTS

In a few instances, organizations which gave information on nursing services also reported on the volume of care provided. One organization with 85,000 subscribers in 1945 reported that 24-hour special duty nursing was provided up to a maximum of 30 days in any one case. This service was paid for at the prevailing rate of a dollar an hour. For the fiscal year ended June 30, 1944, the cost of providing this service averaged a little more than 1 percent of the organization's expenses. The annual cost of the service amounted to $22,389 or approximately 26 cents per subscriber per year.

Another organization gave the following figures on costs of special duty nursing:

Year	Number of persons receiving care	Annual Cost		
		Total	Average per case	Average per subscriber
1939	15	$2,105	$140.35	$.30
1940	10	1,676	168.65	.23
1941	13	1,604	123.42	.23
1942	19	1,056	55.59	.15
1943	20	1,697	84.84	.24

A third organization with approximately 48,000 subscribers reported an annual expenditure of $7,344 for special duty nursing, or an average cost of 16 cents per subscriber per year.

In 1943, one organization serving 8,000 persons, both subscribers and dependents, employed 2 full-time visiting nurses. During that year these nurses made about 3,200 visits to the homes of subscribers, an average of 40 visits per year per 100 persons eligible for care. In a second plan with about 14,250 subscribers, an average of 44 visits per year per 100 subscribers were made. In this plan the average cost per visit was $1.23.

A third organization, with approximately 10,000 subscribers, reported a yearly cost of $5,000 for services of visiting nurses or about 50 cents per person eligible for care. Approximately 40 visits per 100 persons eligible for care were made over a year at an average cost of $1.45 per visit. These visits were made to approximately one third of the members eligible for this service. In addition to the visits reported above, members also received a total of 2,254 visits from the metropolitan visiting nurses association in the city where the plan operates. Through both organizations, a total of 6,335 visits were made or an average of 63 visits per 100 persons eligible for care.

In the fourth organization, services of visiting nurses were available to approx-

imately 9,000 employees in a war industry as part of a medical care program financed entirely by the employers. During 1944, the company paid $9,000 in salaries to the three regularly employed visiting nurses; other costs incurred in providing the services were not reported. During the year, visits averaged about 63 per 100 persons eligible for care.

Since each organization providing information on costs of nursing services used its own accounting method, there is little if any comparability among organizations, though it is clear that nursing services can be provided at reasonable cost. The directors of plans that give nursing services are enthusiastic about the benefits derived by the patients and the organizations. When the nursing shortage is relieved many organizations will doubtless increase their nursing staffs. Other organizations which have not employed nurses in the past have indicated their intention to do so when nurses are available. Salaries have increased greatly during the war years; the beginning salary in one organization for example has risen from $1,200 to $2,000. A few organizations providing information on salaries paid in 1945 indicated a range from an entrance salary of $1,800 to a high of $2,500-$3,000 a year.

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EUROPEAN NURSES NEED CLOTHING

A SPECIAL committee to be responsible for collecting clothing for needy nurses in Europe has been formed by the American Nurses' Association with Wilkie Hughes, executive secretary of the New Jersey State Nurses Association as chairman. According to a recent report from Anna Schwarzenberg, executive secretary of the International Council of Nurses, the Council has received very urgent requests from the national nurses associations in European countries for uniforms, shoes, stockings, capes, and coats for nurses.

Specific requests include:

Belgium—material for uniforms, brown or white shoes and stockings

Denmark—300 uniforms and 500 pairs of shoes

Finland—5,750 nurses need "everything"

France—25,000 nurses and 5,000 student nurses, everything

Norway—3,400 nurses, everything

Russia—500,000 nurses, everything

Yugoslavia—1,000 uniforms

The ICN has been in touch with national relief organizations and is ready to ship materials to the national nurses associations of the various countries for distribution according to need.

The ANA committee is now making plans for collecting uniforms and uniform materials. It is hoped that public health nurses will cooperate in this relief project. However, do not send uniforms or materials until you have further directions. Plans for collection will be made in each state.

Building for Health in My District

By LUCILLE BECKER, R.N.

WHEN the United States entered the war everyone interested in public health was shocked to learn that so many of our youth were rejected from military service because of physical defects that could have been prevented or corrected. Didn't we in public health think we had done a better job? However, Uncle Sam had figures to prove that the health of his people was not 99.44 percent perfect, and had improved very little since 1918. This was a challenge to public health nurses, a challenge to do a better job even now in wartime with less personnel and for more patients in larger areas.

Looking back over my ten years as a public health nurse I reviewed the knowledge and skills at my command. I became determined to improve my work, not only because of the startling Selective Service figures but also because a university public health nursing student was assigned to me for her field training.

With several of our nurses leaving for the Armed Services I was assigned to a larger territory and, to lend further complications, the area to be served had not been studied from a public health viewpoint. The first problem then that faced me and the student working with me was to seek out statistics and resources vital to our program. Our search revealed that this unincorporated area contained a large school district, numerous new one-family dwellings, many churches, one doctor, and one dentist.

Since each student is required to work out a specific project during her affiliation with the St. Louis (Missouri) County Health Department it was decided that my student might make a more comprehensive survey of my new area. We reviewed other survey materials and together compiled a survey form applicable to this community. Then my vivacious blonde student, equipped with questions and a determination to do a good job, went to work.

First she interviewed the superintendent of schools and requested the tabulation of the food rationing registrants to obtain the approximate population figure. He willingly agreed and two high school students were assigned to assist her. The results revealed a community of 8,000 people of which 600 were preschoolers and 200 infants. These figures were of immediate interest to the school. Plans must be made for classroom space for the 200 infants within the next four or five years.

The question arose in the nurse's mind —are these children healthy? How are they to receive medical and dental supervision with one doctor and one dentist?

Next the only doctor was visited. He proved to be a physician past retirement age working only because of the war. He was far too busy to be concerned with the public health needs of the area. The dentist was keenly interested in public health and encouraged the student to continue the survey and learn the needs of the people.

Every known community leader, including the ministers, was visited. The public health nursing student was met cordially and enthusiastically. A good community spirit prevailed. A meeting conducted by the student and nursing supervisor was held in the high school. To-

Miss Becker, formerly on the staff of the St. Louis County Health Department, is now public health nursing consultant in the State Service for Crippled Children, Rheumatic Fever Program, St. Louis, Missouri.

gether they presented the work of the health department and its various fields. The educational director told of the various ways the community could aid in solving its problems by volunteer workers and community activities. Before the closing of this meeting a chairman was selected who appointed various members to serve on committees to study the problem in the respective districts. Another committee meeting was scheduled. Thus the County Health Committee was born and the members of this selected group set about to learn from friends and neighbors what they thought about planning a community health program.

The first meeting was the climax to the public health nursing student's project. On the following day she was scheduled to resume her studies at the university. Her departure from the community was deeply felt but her project carried momentum which remains a tribute to her and her university.

The county health commissioner was asked to participate in the next general meeting which was an informal discussion of a plan of approach to community health problems. His friendly discussion, enthusiastic manner, and knowledge of public health prompted many questions, which showed that this group was becoming conscious of their public health needs. At this meeting the foundation of the Health Committee was cemented with community interest.

Many committee meetings followed and members studied various projects in which the community seemed interested. The child health conference seemed to appeal especially. Several members visited neighboring child health conferences and at a general meeting plans for a conference were laid before the public. Several organization leaders pledged the financial support of their groups.

Each member of the committee earnestly worked many hours to perform the task assigned to him in order to bring to fruition this project for which the district had pledged not only financial but moral support. The local school superintendent, who served as general chairman, was performing a splendid job, working untiringly and giving his advice and support to any member on request. The building committee chairman, a retired businessman, took time to investigate the possibilities of location and selected the basement of the local postoffice for the site of the child health conference. The financial committee chairman, a local banker highly respected by all the townspeople, kept accurate records of gifts, donations, and expenditures. The publicity committee chairman, a young and enthusiastic businessman with the vigor and foresight necessary for his position, kept the community informed of problems and progress. The equipment committee chairman, a local minister whose enthusiasm is far-reaching, worked with the public health nurse in selecting needed supplies. The volunteer committee chairman, a local housewife, exemplified the old saying, "If you want something done, get a busy person to do it." Her activities in her home and community appear to an outsider as an unending chain of events but she always has time and energy to do something more and something better. The priest of the community has an Irish brogue which lends itself to good story telling. He keeps the hearts warm and the spirits soaring as he assists in all capacities and has been responsible for many donations, including wood for partitioning rooms, paint, and painters.

The community has indeed made its first project, namely the child health conference, a successful community affair. The high school art department contributed its work by printing a sign which reads "Affton Health and Welfare Association Child Health Conference" before the outside door of the conference rooms. This indicates to all who pass and read that the community has formed an association interested in the health and welfare of its citizens. Other group contributors were the manual arts class who made a play pen and pamphlet rack; the Girl Scouts who assist the volunteers; and the Brownies, who are furnishing colorful pictures which appeal to the preschoolers and will be decorative on the walls of the conference rooms. As a service project the Brownies also plan to clip advertise-

ments and articles in newspapers and magazines and make notebooks for the conference mothers' perusal on infants, preschoolers, and school age children's problems and habits. Two nearby merchants have allowed the use of their store windows for displays of ideas related to the health problems of the community.

Another group contributing to the health activities of the community are the nutrition students of a nearby university, who assist with teaching and demonstration of food preparation. Public health nursing students conduct group discussions of subjects suggested by mothers at the child health conference. Magazines and pamphlets related to various subjects are displayed on separate tables. *Hygeia* and *Parents' Magazine* are purchased by the committee and placed in covers by a local volunteer, a former librarian. These magazines are then loaned to interested persons. About 30 volunteers from seven surrounding school districts have pledged their services. These volunteers from one school group are invited to assist at each conference. Printed instructions and demonstrations of techniques were given these volunteers by the public health nurse at a general meeting at which the chairman of the local committee greeted the group and election of officers took place. The volunteers organized into a working and study group. The public health nurse in charge of the child health conference supervises the volunteers and instructs them in procedures as often as necessary.

The opening of the child health conference was most successful with a preschool roundup. Parents responded and many health problems were discussed, plans being made for the correction of defects before the opening of school.

In less than one year, this community has assisted materially and unselfishly in the health and welfare of its people. Another project now in progress is a child care center for working mothers, to which the government is contributing with Lanham Act funds. The committee members are meeting monthly and working hard on this second project. The child care center is held in a modern tavern, which, until this time, was locked and barred with signs that read "Closed for the Duration. Gone to Help the Boys." The owner is helping the boys and the contract which was drawn up had to be sent to Saipan for the owner's signature. Now children's voices are heard to sing and shout from the tavern openings, which stands as a memorial to its owner and a haven of free play, fun and learning for the children of mothers who work.

At the last monthly meeting of the Health and Welfare Association plans for a library and possibilities of group play for teen-agers were being considered.

In summarizing, may I repeat and I think you will agree, that my student's project has been worth while; that a health committee is a community necessity, and that nurses should take time to develop community participation in solving health and welfare problems.

Killer No. 5

By MARTHA SCHAEFFER

MORE persons have been killed and injured in accidents in the United States since Pearl Harbor than American fighting men killed, wounded, missing and made prisoners in all the theaters of war.

This does not in any way imply that danger on the home front can be compared with the risks fighting men take on the battlefront. It simply shows the enormity of unnecessary death and injury in this country as compared to meaningful sacrifices of men in uniform.

Accidents in America rank fifth as the cause of death. Among persons from 2 to 28 years of age, accidents are the leading cause of deaths. Accidents kill more than 90,000 Americans every year. In some years, the number of accidental deaths approaches a total of 100,000. Accidents injure close to 10,000,000 Americans every year.

Such figures as these from the National Safety Council support the growing realization that something must be done to awaken the American people to the need for a unified accident prevention program.

It has become apparent during the past two decades that accidents can be prevented. Well organized programs have been developed for the prevention of accidents in industry, in traffic, and among school children. These programs have resulted in measurable reductions in the number of accidents reported. There have been advances in the field of fire prevention, in developing safety standards for public buildings, and in several other specialized fields of human activity. But the greatest need for such a program is in the American home. More than 30,000 people are killed and more than 4,000,000 are injured in homes each year!

How did these people die? More than half of them fell to their death. They fell from makeshift ladders, down cluttered steps, over toys, books or misplaced furniture, from windows in which the screens were not securely fastened, on small rugs, and on icy steps. Their deaths were unnecessary. They were caused largely by thoughtlessness.

More than 5,000 of them died from burns. They smoked in bed, left the current on electrical appliances, or failed to have appliances checked for defects, or left matches within the reach of children.

They died from poisons. Thirty-two percent of those who died from poison in the home were toddlers under four years old. Many got at poisonous household products left unguarded from curious little hands.

More than 1,000 died in firearm accidents. Many are the stories of the gun that "wasn't loaded."

Only through a coordinated program can we hope to meet the problem of saving lives and injuries from home accidents.

Who best can get at this problem through personal contact with the American family? What qualifications are necessary to accomplish the task at hand?

First, there must be the opportunity. Public health nurses, through their work with individuals, with families, with children, with civic and private groups, and with government agencies have this opportunity. The "foot in the door" is important, and the public health nurse already has this opportunity in her regular work.

But chance to do the job without the necessary qualifications is worthless. The nurse has these qualifications. She commands great respect in her work. She is

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rightly looked upon as a person with authority. What she has to say is accepted as being good for the individual, the family, and the community. That acceptance is important in the establishment of any program whether it be on a community, state, or national level.

Then there is a great deal dependent upon the manner of presentation. The public health nurse is trained and experienced in handling people. She knows the most effective method of presenting ideas. She knows the intricate complications of dealing with people. This probably is her greatest asset for accomplishing the task at hand.

There are three basic steps in establishing safety in a home or a community: (1) recognition of hazards (2) removal of as many hazards as possible, and (3) acting to avoid the remaining hazards.

Hazards are not always easy to recognize, but the most obvious ones are the ones which cause the largest number of deaths.

Unsafe conditions frequently exist because of bad lighting which is responsible for many of the home tolls from falls.

A room cluttered with too much furniture or with furniture that is ill-placed becomes another obvious hazard. Toys, sports equipment, brooms, mops and pails, left on stairs or in passageways cause accidents.

Bad wiring is responsible for many home fires. A frayed cord or an unplugged (open) socket is easy to see.

Broken steps, and steps unprotected by bannisters are hazardous. So are highly polished floors, small rugs, and wet or greasy floors.

Poisons, firearms and matches left within reach of children kill thousands yearly.

These are examples of obvious hazards which can be removed. These are the things which the public health nurse may recognize in a moment. Some of these she may report to the proper authorities as unsafe conditions. Others are matters which she may take up with the family for improvement.

After the more glaring hazards are removed, a great deal still depends on the actions of people in avoiding the remaining ones.

Standing on a chair to hang curtains or reach high places is an obviously unsafe act. Using cleaning fluids at home is unsafe under any condition. Leaving electric appliances within children's reach is dangerous. Putting baby to bed with pillows is another unsafe act.

Here again the public health nurse has an opportunity through her personal contact work and through much available literature on the subject to call this problem to the individual or the family's attention.

The greatest help of the public health nurse, according to the National Safety Council, is needed for the protection of the young and the old, because children and aged persons have suffered more from accidents during the war period than any other age group. Deaths of persons 65 years and older make up more than half of the total home accident fatalities. Children under 5 years are second.

The job of saving lives cannot be accomplished by any one group in this nation. The effort must come from a unified effort on the part of all groups and all individuals. But public health nurses have both the opportunity and the qualifications to become one of the strongest and most influential forces for accident prevention in the nation. It is a challenge to every professional man and woman to use power and influence toward the saving of lives and injuries, for accident prevention *is* a genuine public health service.

Reviews and Book Notes

THE TECHNIQUE OF BANDAGING AND SPLINTING

By Arthur M. Tunick, Major, Medical Corps, Army of the U. S. 206 pp. Essential Books, 270 Madison Avenue, New York, 1945. $3.

This book offers a comprehensive and simple survey of its subject. It seems altogether the most satisfactory book on bandaging that the present reviewer has found to date. Many obscure points in bandaging practice, the reasons for which most of us have only scanty knowledge, are shown to be based on definite scientific principles.

The axioms of good bandaging are emphasized at the outset in such fashion that the reader will not be likely to lose sight of them as he follows the various procedures outlined in the book. Complex bandage problems are simplified wherever possible and the excellent illustrations with which the book is generously supplied are responsible for much of the lucidity of treatment. It can be recommended to all nurses who have come to realize that the lost art of bandaging is a necessary part of their equipment in nursing.

CARMELITA CALDERWOOD, R.N.
Cedar Falls, Iowa

FUNDAMENTALS OF BACTERIOLOGY

By Martin Frobisher, Jr., S.B., Sc.D., F.A.A.A.S., F.A.P.H.A. 824 pp. W. B. Saunders Company, Philadelphia, third edition, 1944. $4.

The reorganization of this book seems to be an improvement generally, in comparison with the previous edition. It may be noted that yeasts and molds are considered in Chapters 8 and 9 in this third edition without entirely correcting the impression that they are not in logical order. Chapter V of the second edition considered yeasts and molds.

There are many good illustrations in this text, a few of which are in color. It is to be hoped that this is a promising beginning and that more texts will be able to print more illustrations by the color methods that the magazines have recently demonstrated may be so natural and effective.

The usefulness of the references has been very much improved. Chapter bibliographies are included, replacing the previous list of references at the end of the book.

The new edition includes 47 chapters totalling 824 pages, as compared with the 42 chapters and 653 pages of the second edition. Some important additions to the material covered may be indicated in the words of the author's preface: " . . . methods of cultivation in chick embryos, tissue cultures, electron and fluorescence microscopy, penicillin, gramicidin and related compounds, viruses, including bacteriophage typing, poliomyelitis and lymphogranuloma venereum. There is a pioneer chapter on pleuropneumonia organisms and new discussions of bacteriostasis and sulfonamid drugs, metabolism, environmental factors, home canning and food preservation, disinfectants, aerobiology, ultraviolet light and aerosols in air disinfection, carbon dioxide metabolism, photosynthesis, disease, immunity, paracolon organisms, leprosy, typhus, yellow fever, and many other topics."

It would be an error of omission not to point out, with a nod to the Curriculum Committee of the National League of Nursing Education which makes recommendations for improvements in curricula for schools of nursing, that the title of the book is a misnomer. The content is not limited to bacteriology and deserves a title at least as inclusive as is indicated by the word *microbiology*.

This reviewer has recommended the second edition to students who wished to accomplish a general review of fundamentals without being overwhelmed with as much detail as the larger textbooks emphasizing medical aspects especially are apt to involve. The third edition is even more worthy of such recommendation.

ARTHUR W. TALLMAN, PH.D.
Cleveland, Ohio

RECENT PUBLICATIONS AND CURRENT PERIODICALS

DENTAL HEALTH

COSTS OF DENTAL CARE FOR ADULTS UNDER SPECIFIC CLINICAL CONDITIONS. By Dorothy Fahs Beck, assisted by Mary Frost Jessup under the auspices of the Socio-economic Committee of the American College of Dentists. Lancaster Press, Inc., Lancaster, Pa., 1943. 306 pp. $1.50.

Actual data on cost of providing needed dental care—an important social-economic study.

GOOD TEETH FOR EVERYBODY. By Louise Paine Benjamin. *Ladies' Home Journal,* February 1945, page 149. The Curtis Publishing Company, Independence Square, Philadelphia 5, Pa. Single copy: 15 cents.

Many questions which mothers and public [illegible] nurses should have at "tip-o-tongue" are [illegible]

GENERAL

THERE CAN BE JOBS FOR ALL: BEVERIDGE'S PLAN FOR FULL EMPLOYMENT. By Maxwell S. Stewart. Public Affairs Pamphlet No. 105. Public Affairs Committee, Inc., 30 Rockefeller Plaza, New York 20, 1945. 31 pp. Single copy: 10c.

THE OUTLOOK FOR WOMEN IN OCCUPATIONS IN THE MEDICAL SERVICES. Women's Bureau, U. S. Department of Labor. Write Superintendent of Documents, U. S. Government Printing Office, Washington 25, D. C. Single copies: 10c each.

Professional Nurses. Bulletin 203, No. 3. 1945. 61 pp.

Medical Laboratory Technicians. Bulletin 203, No. 4. 1945. 10 pp.

Practical Nurses and Hospital Attendants. Bulletin 203, No. 5. 1945. 20 pp.

Medical Record Librarians. Bulletin 203, No. 6. 1945. 9 pp.

Additional bulletins in the series, first reported in our April issue, on present opportunities and postwar prospects for women in the medical services.

VOLUNTARY ORGANIZATIONS AND DEMOCRACY: A DISCUSSION OUTLINE. Prepared by the National Federation of Business and Professional Women's Clubs, Inc., 1819 Broadway, New York 23, N. Y., 1945. 26 pp. 35 cents.

INDUSTRIAL HEALTH

COUNSELING SERVICES FOR INDUSTRIAL WORKERS. By Mary Palevsky. Family Welfare Association of America, 122 East 22 Street, New York 10, 1945. 51 pp. Single copy: 60c.

SHOP SAFETY. National Safety Council, Inc., 20 North Wacker Drive, Chicago 6, Ill., 1945. Revised edition. 32 pp. Single copy: 15c to members of the Council; 30c to nonmembers.

UNION COUNSELLING: A NEW CIO SERVICE FOR INDUSTRIAL WORKERS. National CIO War Relief Committee, 1776 Broadway, New York 19, 1945. 8 pp. Free.

Describes CIO out-plant service referral program being developed in cooperation with community welfare agencies in industrial areas.

MEDICAL ECONOMICS

SELECTED BIBLIOGRAPHY ON MEDICAL ECONOMICS. By Helen Hollingsworth and Margaret C. Klem. Bureau of Research and Statistics Memorandum No. 60. Available from the Bureau, Social Security Building, Washington, D. C., 1944. 21 pp. Free.

This is the first of what we hope will be a series of monthly columns about public information programs. To help insure the column's usefulness, NOPHN needs your cooperation. Send us examples of what you are doing to promote better understanding of public health nursing services. For example, what has your community done to follow up the interest created by Public Health Nursing Day? Now that a draft of nurses is no longer needed, is your community ready to intensify interpretation of home front services? Share your plans and ideas through this column.

EDITH WENSLEY

Public Information Tips

A SOUND QUESTION to ask when planning public information programs is, "What is the other fellow interested in hearing or reading or learning about my subject?" Too often a leaflet, annual report, talk, or radio program seems to have been guided solely by the reverse question, "What do I, the writer or the speaker, want to say?" A series of programs prepared according to the first principle was sponsored this year at Boston by the Community Fund and the Visiting Nurse Association. These programs were staged as interviews with the director of the VNA, the announcer, and a third person—usually an authority in the particular subject under discussion—as participants. Program title was "Let's Talk about Children," and subjects of individual broadcasts included: how to prepare for the coming of baby, care of children's teeth, habit training, convalescing child care and recreation, health and safety measures, wartime traveling with children.

Radio programs like these—and talks at meetings, too—help establish the public health nursing organization as an authoritative source of information and guidance. They bring the public health nurse closer to the listener than do talks in general terms about "services." Furthermore, they are one important means of extending her service beyond the group of people she reaches in her daily visits. Copies of the scripts are included in NOPHN'S revised loan folders on radio.

. . .

Radio writing is a specialty requiring not only ability but also detailed knowledge of radio techniques. That is why all scripts for radio should be prepared by a specialist in radio or at least checked by somebody familiar with radio. This is particularly true of dramatic scripts, for writing good dialogue is "tricky" and requires considerable "know-how." One script which came to our attention dramatizes a conversation between a mother and a nurse. In this the mother asks, "Where may the public health nurse help on the adult level?" and "But, after the mother goes for her postnatal examinations, the baby is many times not under a doctor's care. What happens then?" Would the average mother say this? Would the average listener understand the meaning? Would the average listener listen?

. . .

Annual reports are always news. But the Visiting Nurse Association, New Britain, Connecticut, has devised a novel way of presenting its annual report to the public—novel at least for public health nursing associations. This year the report appeared as a quarter-page advertisement with attractive illustrations; gives highlights of the year's activities and a brief financial statement. The same plan has been used by the Boyd County Health Department, Ashland, Kentucky. Here a full page was devoted to reports about health department services. However, not many newspapers would be so generous with space. The usual plan is to issue a printed or mimeographed annual report as a permanent record and use it as the basis for a news release to all local papers.

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The Visiting Nurse Association of New Britain, Connecticut, also has an admirable plan for keeping the community up to date on new developments. When nursing shortages first became critical, the Association issued a simple mimeo-

(Continued on page A8)

NEWS AND VIEWS

Highlights on Wartime Nursing

CORPS EXCEEDS 1944-45 QUOTA

Quota of 60,000 enrollees for the U. S. Cadet Nurse Corps for the year ending June 30, 1945, was surpassed by a total of 1,471 new student nurses in the second consecutive year the Corps has exceeded its recruitment goal. For the last six months of 1945 the annual quota will be 40,000 students—the same as for the similar period last year. Military and civilian nursing needs will be reviewed by the USPHS late in the year to determine whether any change in the student nurse quota is indicated in relation to the course of the war.

Many thousands of nurses and hospital administrators who have worked as volunteer recruiters in local and state affiliates of the National Nursing Council for War Service and the American Hospital Association are credited in great part for the success of the recruitment efforts for 1944-45. Another important contribution to the drive's success has been the donation of news and advertising space by industry, the press, radio, and screen without cost to the Government.

In an editorial in the *Journal of the AMA*, April 14, Surgeon General Thomas Parran paid tribute to the recruitment effort of the Corps, calling it "probably the most successful of the war." He cited the successful engagement of the Corps in essential civilian nursing as well as military service. "The recruitment program of the U. S. Cadet Nurse Corps," he said, "has contributed immeasurably toward preventing a collapse of nursing care in civilian hospitals."

NATIONAL CAMPAIGN FOR NURSES

A national information campaign is being inaugurated by the Office of War Information and the War Advertising Council to help meet the acute need for nurses and auxiliary workers now existing in civilian hospitals, public health agencies, the Veterans Administration, and to recruit students for the U. S. Cadet Nurse Corps. National organizations assisting with the program are: American Hospital Association, ANA, ARC, NLNE, NNCWS, NOPHN, Procurement and Assignment Service of WMC, USPHS, and the Veterans Administration.

The campaign is designed to: (1) encourage nurses in civilian hospitals and public health nursing services to continue at their jobs, urge those in jobs not essential to accept essential jobs, and urge inactive nurses to return to active nursing (2) recruit nurses for the Veterans Administration (3) recruit students for the U. S. Cadet Nurse Corps (4) recruit auxiliary workers, trained voluntary nurse's aides, and home nursing students (5) appeal to the public to keep well and avoid need for doctors and nurses, to postpone unnecessary hospitalization, and to use nursing care only as the doctors think necessary.

The national campaign will serve to inform the public of the need, but the success of the undertaking will depend upon efforts in the states and local communities. State and local branches of all these organizations are urged to start organizing for the campaign at once.

P & A FUTURE PROGRAM

The Directing Board, Procurement and Assignment Service, has announced that, because of the change in military needs—which for the present have been met—P & A will operate on a diminishing basis. Local committees are asked, therefore, to select those activities which will make the greatest contribution toward meeting the critical needs in essential civilian nursing services. Students graduating in the remaining months of 1945 and the nurses classified in Class I constitute the largest pool from which to meet these critical needs. It is recommended that state and local committees give immediate attention to the classification of student nurses (See Nursing Information No. 12 Revised) and the follow-up of nurses in Class I (See Nursing Information No. 14 Revised), especially those who graduated in 1944 and 1945 and because of urgent military needs were in most cases automatically classified in Class I. Special at-

tention should be given to classifying cadet nurses who pledged to remain in essential civilian service for the duration of the war.

Because of a critical need for well prepared nurses in schools of nursing and public health agencies, the Board announces a return to a former directive of July 15, 1944, on "Classification of Nurses Enrolling in Postgraduate Courses," which will make it possible to classify more nurses who plan to study as essential.

Because Cadet nurses have pledged to stay in essential service and the response of the great majority of nurses to accept their wartime responsibility has been excellent, Procurement and Assignment feels it still has an important function to perform.

NEW BRITISH CONTROL ORDER AFFECTS NURSES

British Control of Engagement Order 1945, which became effective in June replacing all earlier orders made by the Minister of Labour and National Service, makes the position of nurses, midwives, physiotherapists, radiographers, and qualified nursery nurses the same as during the European War, reports *Nursing Times* for June 2, 1945. No one practicing any of these professions, if between 18 and 40, may obtain work except through a local office or approved employment agency, with the following exceptions: women who have living with them children of their own under 14 years of age; women registered under the Blind Persons Act; women who have a Ministry of Labour permit to allow them to obtain employment for themselves. Application of the new Order to nurses and midwives results from the acute shortage. It means the year of special service will still be required from newly-qualified nurses and the practice of midwifery from midwives who take the full training. The Order is designed to prevent difficulties during the period between the defeat of Germany and the defeat of Japan, and also in the period during which persons are being released from the Services and must be allocated on a voluntary basis to the services which need them most.

"With regard to nurses released from the Nursing Services of the Crown," states the *Times*, "the Order will not affect them during their period of paid leave, nor during the period in which they can, if they wish, claim to be reinstated in their pre-Service employment. After these periods have elapsed, it will apply to them. On the other hand, we would remind them that, for all posts of ward sister and for other administrative posts, hospitals are able to get certificates of exemption, so that they are advertised in the nursing press and any nurse suitably qualified, whatever her age, can apply."

USPHS JOB SURVEY

A survey of needs of state and local health departments for all public health personnel including nurses is being undertaken by the U. S. Public Health Service. This information is being gathered in order that returning veterans may be acquainted with the opportunities and openings in this field. Results will be made available to the agencies engaged in finding positions for the officers, men, and women released by the Armed Forces. It is felt that numbers of persons can qualify for careers in public health as a result of the professional and technical training and experience while in service.

A questionnaire has been sent to all state and local health officers requesting information regarding all staff positions established, the number of these currently filled, the number of positions held for persons in the Armed Forces which are now vacant or temporarily filled, and the number of other vacancies. This data should give a valuable picture of openings available throughout the country for returning veterans. The positions listed include all possible types usually available in a health department.

From Far and Near

● The Bureau of Public Health Nursing, District of Columbia Health Department, announces openings in the positions of associate public health nursing consultant, pediatrics, and associate public health nursing consultant, maternity, with salary range for each of $3640-$4300. A 40-hour, 5-day week is being established. Write Josephine Pitman Prescott, director, Nursing Bureau, 301 C Street, N.W., Washington, D.C.

● Lillian J. Johnston, Nurse Officer (R), USPHS, has been appointed Chief Nurse, Health Division, of United Nations Relief and Rehabilitation Administration. She has been Acting Chief Nurse since March 1944, and is the

first Chief Nurse to be appointed. Her responsibilities include maintaining contact between UNRRA and other organizations concerned with nursing on an international scale, such as Rockefeller Foundation and the International Council of Nurses, and determining qualification standards to be used in the recruitment of all American and Canadian nurses for UNRRA. She will work also in conjunction with the European Regional Office to secure competent French and other native European nurses to help in UNRRA's nursing program. Miss Johnston is a graduate of Hartford Training School for Nurses and Teachers College, Columbia University.

Group Health Cooperative Enrollment Increases—Since visiting nurse service was added to the benefits of the Group Health Cooperative, New York group health plan, June 1, 1945, there has been the most rapid increase in enrollment in its history, according to Charles Marlies, president of the Plan. More than 3,500 new subscribers were secured during June. "In every case, employers are paying either a large share or all of the premiums for their employees," Mr. Marlies reported. In some instances, the Plan is a part of agreements with trade unions. In the opinion of Mr. Marlies, this increasing interest on the part of employers shows a growing recognition of the value of insurance against the costs of medical care as an essential element in employee welfare programs. This Group Health Plan pays doctors' bills in all hospitalized illnesses and in cases requiring surgical care outside the hospital for a premium of 80 cents a month for an individual or $2 for a whole family.

Connecticut Cancer Program—Connecticut has an active cancer program in effect 12 months of the year under three groups in the State: the Medical Society, the State Department of Health, and the Connecticut Cancer Society. Through the cooperation of the medical profession, the superintendents and staffs of the hospitals, and the interest of patients who have had the disease, they have evolved a statewide record registry of persons who have been treated for cancer and are still living. The information from all over Connecticut is grouped by the State Department of Health for the better understanding of the problem as a whole. Efforts to increase the improvement in the control of cancer are guided by analysis of this data.

Follow-up of all living cancer cases was given impetus in 1941 when the Connecticut General Assembly appropriated funds for this program. It is an important factor in producing the excellent results of the program, a marked increase appearing since 1942 in the number of those with cancer seeking medical aid at an early stage, although this increase may in part be attributed to increased educational activity. Another factor is the earlier detection of suspected cancer by an aroused profession. In other words, the State cancer program has resulted in improved services for individuals who have or may develop cancer.

Social Redirection of Women with VD—Studies of the social, mental, and emotional make-up of venereally infected women patients with a view to using community resources for their redirection were undertaken in the Midwestern Medical Center, an intensive treatment hospital in St. Louis, Missouri, set up by the USPHS. The group studied, according to Virginia Fenske and H. L. Rachlin, M.D. (*The Family*, May 1945) were girls and women ranging in age from 12 to 47 years, with 20 years as the median age for both white and Negro patients. Psychological tests showed their median mental level to be in the lower limits of the dull normal range. Only 12.6 percent had an I.Q. in the normal range or above; 37 percent were in the "mentally defective" classification. Social background of the patients indicated them as emotionally handicapped. About 52 percent came from broken homes. Some of the patients had been born out of wedlock, some had lived with stepparents or in foster homes. A large percentage were separated or divorced; and many of them had been married at an early age, some more than once. Employment history of the patients was also unfavorable; many did not have jobs suited to their mental ability or worked only irregularly.

Sexual activity began for white girls at between 14 and 19 years, and for Negro girls, between 14 and 17. Sexual intercourse was usually not for money, but rather for a good time; these girls would not be considered prostitutes.

Since the average length of stay of the patients was reduced with more rapid therapy to under two or three weeks, limiting any opportunity for direct psychotherapy, a diagnostic service to determine what community resources could best be utilized was developed. The patients also were given an opportunity for some kind of work training.

The criteria of selection of patients needing social agency referral and capable of utilizing such service were based on (1) the patient's mental ability and aptitudes (2) emotional stability (3) desire for service (sometimes created during the hospitalization period) and (4) interest and ability of relatives to assist in pa-

tient's adjustments. About one-half of the female patients were referred to social agencies for follow-up care and redirection. The exclusion of many of the mental defectives from the follow-up service, because of its unavailability in the community, was a serious lack. Other patients not referred to a special agency included those "who showed evidence of maturity and ability to make their own plans, who had strong support from their relatives, and were willing to accept such guidance, and also those girls too damaged mentally and emotionally to utilize social agency service." Patients were most frequently referred to protective and court agencies, family and children's services, travelers' aid societies, agencies providing housing, recreational agencies, and medical agencies. Often the protective agencies were already interested and the patient needed to finish a parole or probation period. Some patients were referred to private physicians and to psychiatric clinics offering psychotherapy.

In the opinion of the authors, social agencies need to assume a more active role in following up this type of patient. A case should not be closed without some effort at actively directing the girl. Many of these girls, they stated, are seriously damaged emotionally, but a certain percentage of them will be amenable to complete redirection, and social agencies have a real service to offer them in a supportive and protective role.

Evaluation of Results of Polio Treatment—As a first step to determine uniform means of evaluating the end results of the different methods of treatment of the after-effects of poliomyelitis, the Committee on Standards of the Scientific Advisory Committee of the National Foundation for Infantile Paralysis suggests these requisites to the evaluation for the benefit of physicians responsible for the care of such patients (*Journal of the AMA*, May 5, 1945): (1) accuracy of diagnosis (approachable but not ideally attainable) (2) equal sampling of cases (difficult because symptoms vary from undetectable in one patient to rapidly fatal in another) (3) adoption of a control method, particularly the alternate paired case method, with age, severity of attack and extent of paralysis being taken into account whenever any method of treatment is to be appraised.

The Committee recommends the assessment of muscle strength as soon as it can be carried out with reliable accuracy and without detriment to the patient and that the testing be as objective as possible. Emphasis should be placed on the standardization of a scheme of muscle evaluation which can be widely applied by adequately trained physical therapists, by orthopedists or by any physician trained in the technic of the test. For the purpose of recording residual paralysis, common usage has demonstrated the resistance tests with and against gravity to be the most practicable.

The Committee has examined a number of muscle charts in use in different parts of the country and is working on the design of a form combining the advantages of all. It is hoped through use of the forms, active interest in objective evaluation of the patient's status will be fostered and the comparison of groups of patients treated by different methods, greatly facilitated.

" . . . Most of the contentions over the relative effectiveness of one or another mode of therapy have dealt with the manifestations evident at a comparatively late stage of viral invasion, at a time when the infectious agent either is firmly established or has already inflicted irreparable damage, whereas there is no argument whatever over the disappointing results of all efforts to kill the virus within the host or by artificial means to neutralize its attack. When a truly effective virucide at last becomes available to clinical medicine, all efforts to set up standards for the evaluation of treatment of after-effects may be expected to lose their point."

Serum for Whooping Cough—Studies of the use of human hyperimmune pertussis serum, according to Harriet M. Felton, M.D., in a statement adopted for publication by the AMA Council on Pharmacy and Chemistry (*Journal of the AMA*, May 5, 1945), indicate that it is possible to lower the mortality rate of whooping cough decidedly by the administration of the serum in adequate amounts. Significant passive protection has been obtained when the recommended dosage has been used. Although the incidence of the disease has dropped significantly during the past five years, the mortality rate in children under one year of age continues to be very high. It has been estimated that about 25 percent of the infants under six months of age who contract whooping cough succumb. Active immunization cannot be applied directly to this highly susceptible group, since it is felt that the mechanisms for producing active immunity are not mature. Therefore, a specific prevention and treatment agent has been sought containing specific antibodies in large enough doses to combat existing infection. Until very recently there has been no therapeutic measure which has been able to influence the clinical course of the disease, particularly in young infants. The development of the specific human serum has been under way for less than ten years. Observa-

tions made thus far have been on small groups and without untreated control cases.

Personal Liberty and Venereal Disease—A sweeping revision of the state Public Health Law in respect to venereal disease control was signed in April by the governor of New York, reports *Health News* for May 28, 1945. The revised law provides full-time health officers and district state health officers with the legal tools for the control of recalcitrant persons with infectious venereal disease. Under it, the person named as a contact of the patient known to have a venereal disease, or the person found to have a positive serological test in the course of a routine examination may be advised to seek examination by his physician. Upon his refusal to do this the health officer may order him to do so and upon continued refusal the officer may apply for a court order which may direct submission to examination or to alternative quarantine.

Need Better Housing in Rural Areas—"The plight of the farm family is far worse than that of the city dweller," stated Mrs. Samuel I. Rosenman, chairman, National Committee on Housing, at a recent Working Conference on Farm Housing. In 1940 crowding was more general in rural homes than in urban. Nine percent of the latter exceeded the minimum measurement of overcrowding, while 16 percent of farm homes exceeded that figure. In the South, it was 25 percent. In that same year, only 18 percent of farm homes had running water in the house, only 11 percent had a private bath or shower or flush toilet; almost four fifths of the families had outside toilets, more than nine percent had no toilet of any kind. The war's end, according to Mrs. Rosenman, finds the condition of these houses unimproved. Increased money in farm hands during the war mattered little because material and labor for repair was scarce, and many farmers had debts to work off. To round out the national prosperity cycle better housing in rural areas is necessary. Our immediate concern, the Housing Committee chairman stressed, is that the farmer have new housing where necessary and repair and modernization of the old where it is worthy.

Plan Now for Fuel Conservation—All fuel will be scarce next winter, despite the defeat of Germany. The war in the Pacific and civilian needs will cause coal requirements to continue exceedingly high, whereas the mines will still lack manpower to produce enough to meet these requirements in full. In the face of continuing shortages the need for conservation by all users is inescapable. Nearly every user must make a lesser amount do the work of normal quantities. Conservation need not mean going without sufficient heat. It should mean getting from the limited supply of fuel available enough heat to keep the home, school, office, or shop healthfully warm. This can be done by using fuel more efficiently, which entails anticipating and preventing heat losses.

Because of their entree into homes and the value placed upon their advice and instruction, public health nurses are asked by the Solid Fuels Administration for War to urge civilians to prepare for winter now by doing the following:

1. Store now whatever kind and quantity of fuel your dealer can let you have. If you burn coal or coke, don't wait for some preferred kind that may never be available, or insist on getting more than your fair share. Take your dealer's advice on your coal problem.

2. Check up on all heating equipment, whether fired by oil, coal or gas, to insure peak efficiency. Clean your furnace and install controls or other heat-saving devices where available. Learn how to get the full amount of heat from the fuel you use.

3. Protect your home against loss of heat by installing insulation, storm windows, and weather-stripping. The work can be financed with convenient monthly payments suited to your income on the FHA Plan. "Heat-sealing" pays big dividends by cutting your fuel bills.

Promotion of Public Health Education in 1944—According to the 1944 review of activities of the Rockefeller Foundation, most significant contribution of the International Health Division to public health last year was in the field of public health education. Substantial sums were appropriated by the Division for fellowships and travel grants and for the support of schools of hygiene and public health nursing. Nursing schools in Canada, Colombia, Brazil, Ecuador, Argentina, Venezuela, and Portugal received the Division's support—on the theory that the development of public health work depends in no small measure on the public health nurse and that public health nursing can be advanced only as the profession of nursing is improved.

Operating budget of the International Health Division—established in 1913 and the oldest Division of the Foundation—in 1944 was $3,200,000. In addition to its participation in public health education, Division activities included control and investigation of specific diseases and assistance to state and local health administration.

NEWS NOTES

Safeguards in Adoption—The principles in "Essentials of Adoption Law and Procedures," prepared by the Children's Bureau as a guide to those directly concerned in developing and revising adoption laws and related legislation, are, in brief, as follows:

Protect the child from unnecessary separation from parents who might give him a good home and loving care, if sufficient help and guidance were available; from adoption by people unfit to have responsibility for loving, rearing, and training a child; and from interference long after the child has been happily established in his adoptive home, by natural parents who may have some legal claim because of defects in the adoption procedure.

Protect the natural parents from hurried decisions to give up a child, made under special strain and anxiety.

Protect the adopting parents from taking responsibility for children about whose heredity or physical or mental capacity they know nothing; from later disturbance of their relationship to the child by natural parents where legal rights have not been fully protected.

The welfare of the child, the rights of the natural parents, and the security of the adopting parents can be safeguarded by observance of the following principles of good adoption procedure: (1) Adoption proceedings should be before a court accustomed to handling children's cases, in the locality or state of the adopters (2) The court should have the benefit of study and recommendations by the state welfare department in each case (3) Consent to adoption should be obtained from the natural parents or guardian (4) Court hearings should be closed to the public and the confidential nature of the records assured (5) A period of residence in the adoption home, preferably for one year, should be required prior to issuance of the final adoption decree (6) Provision should be made for removal of children from homes found unsuitable, and for their care and guardianship after removal (7) Safeguards should be provided in related laws to assure the welfare of the child and the rights and obligations of the parents.

Public Schools Study Cancer Control—"Fight Cancer with Knowledge" is the keynote of a growing movement in the public schools to develop cancer control study programs. The common thought that cancer is of little consequence to youth is erroneous, states H. D. Fish, director of School Service, American Cancer Society in *Education for Victory,* February 20, 1945. On the contrary, cancer kills more than twice as many persons below the age of 20 as die of infantile paralysis. Furthermore, in cancer's effect upon the home—its destruction of mothers and fathers and its economic costliness—it is of great concern to youth. An awareness of its symptoms on the part of the public is an important means of attack against cancer. As a result of the study of cancer control in the public schools, children are helping to save the lives of their fathers and mothers. According to Mr. Fish, physicians attest to this. More than 40 states now have or are developing cancer control study programs for their public schools. Such study is not an *added* subject but can well be mentioned in any class in school—biology, general science, health and physical education as well as the social subjects, English, history, dramatics, art and manual training.

In Nassau County, N. Y., a committee of interested medical, social, and educational experts wrote, published, and distributed to the high schools a study outline, later copied and modified in Montana, North Dakota, Minnesota, Wisconsin, and Alabama. Other states, such as Iowa, Michigan, New York, Virginia, Florida, and Connecticut, either have distributed study outlines or are developing them. The American Cancer Society has recently published a study outline suitable for use or adaptation in every state. For literature send to: School Service, American Cancer Society, 350 Fifth Avenue, New York 1, N. Y.

REPRINTS
from PUBLIC HEALTH NURSING

Of the articles which appeared in the April and May issues of PUBLIC HEALTH NURSING the following have been reprinted and are now available:

Salary Scales and Bonuses, 1944 ..... 05c

The Role of the Nurse in Speech Correction—Comments on the Role of the Nurse in Speech Correction ..... Free

Public Health Nursing Functions in Vocational Rehabilitation—Public Health Nursing and Vocational Rehabilitation and Rehabilitation Process ..... Free

More About Wartime Adjustments 05c

Functions of the Public Health Nurse in a Tuberculosis Control Program 05c

Biography of a "Day" 10c

Volunteers in the School Health Service 05c

Public Information Tips

(Continued from page 427)

graphed leaflet, explaining they were still anxious to have people call for a nurse during the early stage of sickness and learn as much as possible from her about "methods of preventing illness and the nursing care and comfort of patients who are ill at home." Now the Association has followed up this leaflet with another titled "Five Out of Thirteen Visiting Nurses Have Gone to War." It begins, "This is a thank-you message," repeats its suggestions for helping stretch nursing service so that patients who are most sick may have essential care, and again urges people to learn as much as possible about preventing sickness. In conclusion: "The Visiting Nurse Association truly thanks New Britain people for their remarkable understanding and participation in meeting this unprecedented visiting nurse crisis, and trusts that in so doing, nursing service to wounded men may have been extended." It's all excellent public relations, and would be very effective on the radio, too, and as a letter to the editors of local newspapers.

PUBLIC HEALTH NURSES—Knoxville Area. Generalized nursing service in a new and growing health department with unusual opportunities. Starting salary $2500 per annum, or higher depending upon qualification. Opportunity for advancement. Apply: Health Officer, Oak Ridge Department of Health, P.O. Box 486, Oak Ridge, Tennessee.

THE CHICAGO LYING-IN HOSPITAL AND DISPENSARY OF THE UNIVERSITY OF CHICAGO

offers to qualified nurses the following courses:

(1) Four months—Basic course for those who wish broader experience in Obstetric Nursing. This course includes experience in hospital and dispensary services. Full maintenance is provided.

(2) Four months—Advanced course for those who wish to prepare for positions of responsibility in Institutional or Community Obstetric Services. Open to registered nurses who have had experience or advanced study in institutional or public health nursing. Charge made for part of maintenance cost.

The Gussie DeLee scholarship of $100 available each year for this course. The Nursing Education Department of the University of Chicago will grant credit to students who satisfactorily complete the advanced course and who meet the admission requirements of the department.

For further information apply to
DIRECTOR OF NURSING
5841 Maryland Avenue **Chicago 37, Illinois**

GEORGE PEABODY COLLEGE FOR TEACHERS

Public Health Nursing

Certificate and Degrees

Professional Preparation in Health and Nursing Education for School, Rural, and Urban Public Health work, including field experience. Educational phases of the work are emphasized.

SUMMER QUARTER
Registration Days—June 11, 12

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Registration Day—September 24

For Information and Bulletin address
Division of Nursing Education

GEORGE PEABODY COLLEGE FOR TEACHERS
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Foley FOOD MILL

Guaranteed by Good Housekeeping

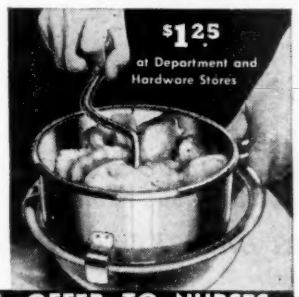
Mothers save food and energy in starting Baby with the full flavor and food value of properly cooked FRESH vegetables and fruits strained through the Foley Food Mill. Just a few turns of the handle separate fibers and hulls and strain any food fine enough for the smallest baby or for any adult smooth diet. It is quicker, easier, and cheaper.

Quickly Strains

Carrots	String Beans
Spinach	Soups
Tomatoes	Peas
Apples	Beets
Apricots	Prunes
Liver	

HOW TO COOK BABY'S FOOD

Proper methods are given in booklet sent with Foley Food Mill.



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☐ Send free booklet, Strained Food Methods
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In the Relief of Externally Caused Skin Irritations

For over 60 years Cuticura Ointment, an emollient containing sulphurated petrolatum and oxyquinoline, has been extensively used as an aid in relieving eczema itching, pimples, industrial dermatitis, sheet burns, chafing, chapping, diaper rash, rectal and other externally caused minor skin irritations. Best used in combination with mildly medicated Cuticura Soap. FREE samples to nurses on request. Write Cuticura, Dept. PH2, Malden, Mass.

Mildly Medicated
CUTICURA OINTMENT

NEW FINDINGS

Resulting from a project conducted by 5 great American universities* reveal the value of canned foods as a low-cost source of

ASCORBIC ACID

**Detailed report published in the August 10th, 1944, issue of The Journal of Nutrition*

For the first time, reliable evaluation tables are now available indicating the relative nutritive qualities of a wide variety of *canned* foods.

This advertisement presents specific data regarding ascorbic acid. Succeeding advertisements will deal with other vitamins.

Canned orange juice leads other canned foods in ascorbic acid values, as might have been expected. The research revealed an average of 39.4 mg. per 100 gm. In other words, a single 8-oz. glass of canned orange juice can be expected to supply more than the recommended daily allowance of 75 mg.

Among the foods studied, next best sources of ascorbic acid in cans were canned grapefruit juice, (33.8 mg. per 100 gm.) and canned grapefruit segments, (24.6 mg. per 100 gm.)

Other good sources, in order of ascorbic acid content, were canned tomatoes — canned all-green asparagus — canned tomato juice—canned spinach—canned peas (sweet Alaska).

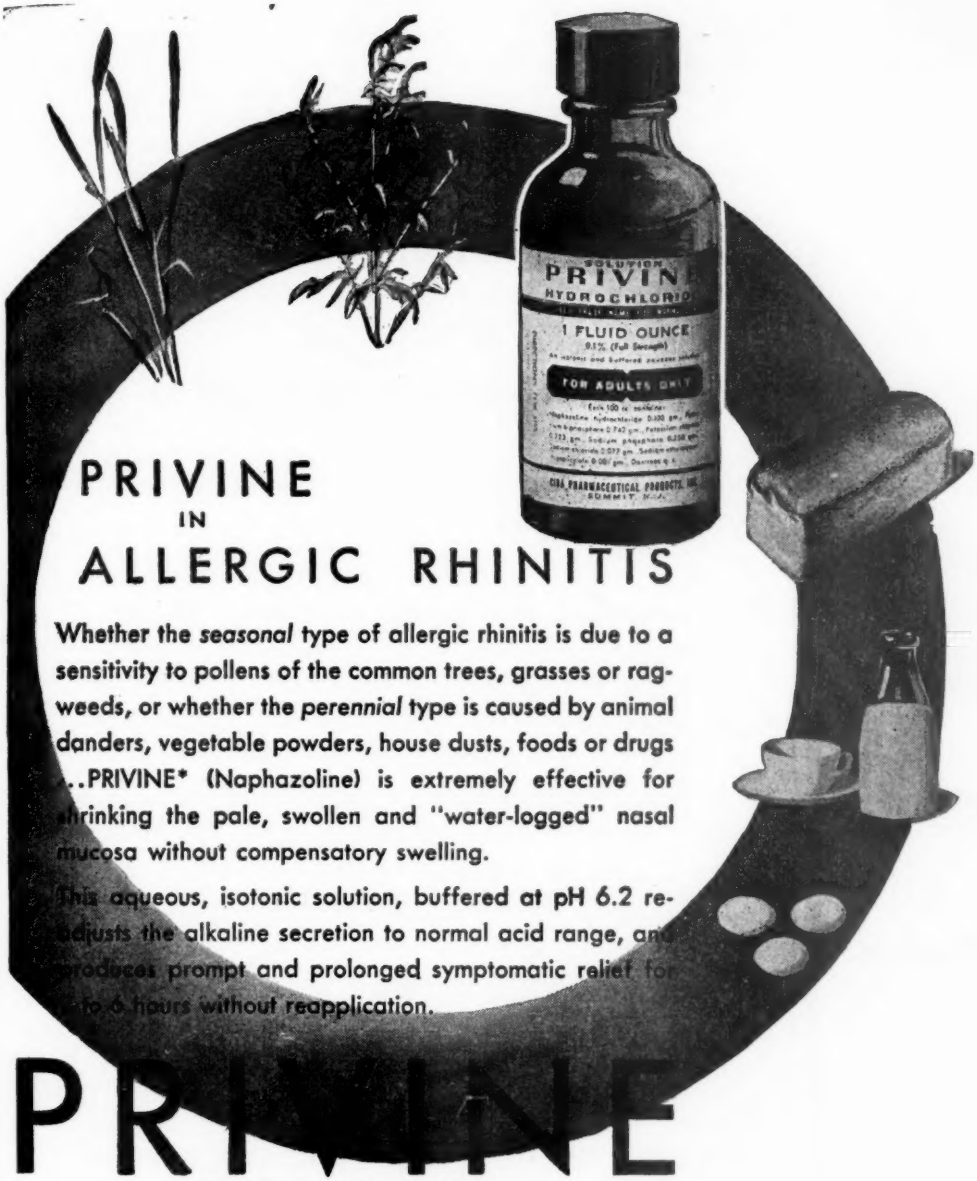
Thus the vitamin values of canned foods run generally parallel to so-called "fresh" foods, with relatively small average losses in the commercial canning process. This is especially significant for one important reason:

Because all canned foods are *processed*—ready to warm or chill and eat—the nutritive values for canned foods are *net* values. This contrasts with the *gross* values always quoted for raw foods, such as vegetables, which are subject to widely varying deductions for losses resulting both in transit from field to kitchen and in home preparation, which is too often destructive, especially of the water-soluble vitamins.

As a reader of this publication, you play an important part in helping to form public dietary habits. We urgently request your valuable support in disseminating information regarding the good values of canned foods in supplying nutrition at low cost. As an aid, an interesting leaflet has been prepared, in lay language. Upon your request we shall be happy to send one or more copies for your use. Please address:

CAN MANUFACTURERS' INSTITUTE, INC., 60 EAST 42nd STREET, NEW YORK 17, N. Y.

No other container protects like the can



PRIVINE
IN
ALLERGIC RHINITIS

Whether the *seasonal* type of allergic rhinitis is due to a sensitivity to pollens of the common trees, grasses or ragweeds, or whether the *perennial* type is caused by animal danders, vegetable powders, house dusts, foods or drugs ...PRIVINE* (Naphazoline) is extremely effective for shrinking the pale, swollen and "water-logged" nasal mucosa without compensatory swelling.

This aqueous, isotonic solution, buffered at pH 6.2 readjusts the alkaline secretion to normal acid range, and produces prompt and prolonged symptomatic relief for 4 to 6 hours without reapplication.

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IN CANADA, CIBA COMPANY LIMITED, MONTREAL

In the Maintenance of Water-Balance

The dynamic equilibrium between intravascular and tissue fluids derives its stability and its adaptability to the body's flexible demands from the plasma protein of the circulating blood. Unless this regulating influence of the plasma protein is maintained, the normal interchange of fluids between blood and tissue becomes disturbed, and edema ensues.

Control of the vital water exchange depends upon both proper constitution and quantitative adequacy of the plasma protein. For its maintenance and regeneration plasma protein depends on the amino acids derived from the proteins of the foods eaten.

Among the protein foods of man meat ranks high—not only because of the percentage of protein contained, but principally because the protein of meat is of high biologic quality—able to satisfy every protein need.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

AMERICAN MEAT INSTITUTE

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TAMPAX "Educational Manual" AVAILABLE TO NURSES!

Found increasingly helpful by teaching staffs in various parts of the country, this manual (just revised) contains highly factual, and interesting information on such important subjects as the *purpose, function and hygiene of menstruation.*

Based on the latest scientific (as well as historical) data, the manual is not only *comprehensive*, but *thoroughly documented* and *well illustrated.* Anatomical colored charts and medical abstracts from outstanding publications supply invaluable data for instructional work.

Interested nurses, hospitals, and public health and industrial organizations may obtain copies of the TAMPAX manual without charge or obligation, by filling out the coupon below. Also available, Students' Question-and-Answer folders.

PH-85

TAMPAX INCORPORATED, 155 E. 44th St., N. Y., *Educational Dept.*

Please send, without cost or obligation, the following:

☐ Tampax Educational Manual "How Times Have Changed."
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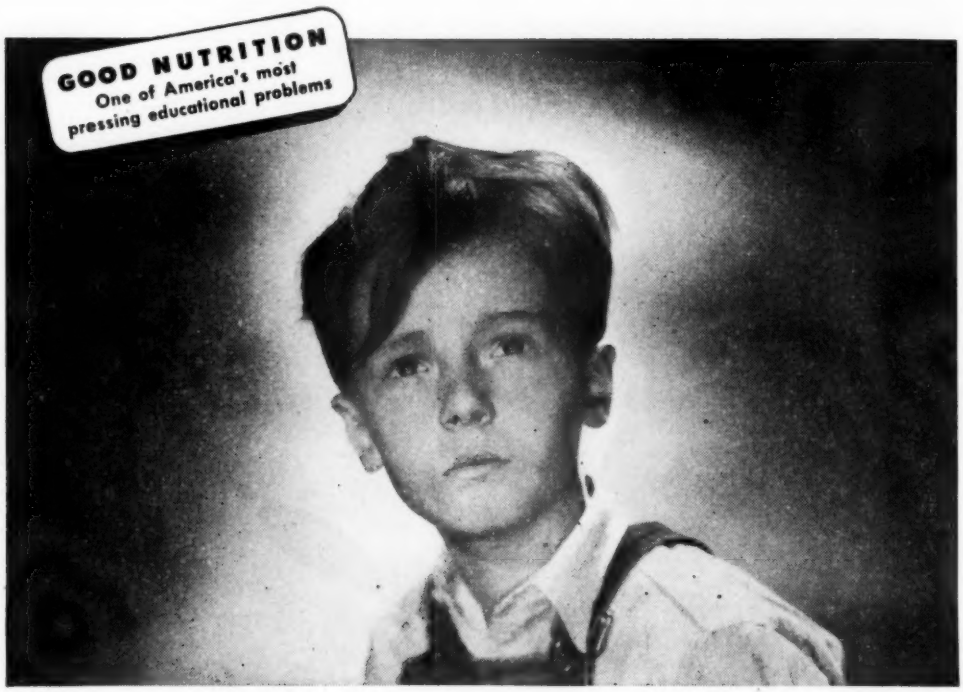

ANOTHER VICTIM?

In 1943, 1,363 Americans died of pellagra*, an easily preventable deficiency disease.

For more than 25 years it has been known that pellagra is caused by a deficient diet. Yet each year Americans die of it.

In 1943, no less than 4,809 cases were reported. More than a thousand deaths were recorded.

Obviously, pellagra is an extreme result of improper nutrition and is relatively rare. But authorities agree that moderately deficient diets . . . the kind that result in lowered stamina and lowered physical fitness rather than obvious and acute illness . . . are not rare at all but widespread throughout the nation.

They agree further that part of the answer to this problem is nutrition education.

Here at General Mills we are trying to help by developing materials which we hope will be usable in teaching good nutrition to school children.

These materials will be based on the latest authoritative information, will be perfected with the help of a committee of educators and will be thoroughly tested in the months to come with the cooperation of a number of rural, suburban and city schools.

Progress of this work will be reported to you on these pages. We invite your comments and suggestions.

* *From Bureau of Census and U. S. Public Health Service Records*

General Mills, Inc.

Minneapolis, Minnesota

Enriched Flours • Restored Cereals • Vitamin Products

EVERY DAY'S DIET SHOULD INCLUDE THESE FOODS

GREEN AND YELLOW VEGETABLES . . . some raw, some cooked, frozen or canned. At least one serving a day.

ORANGES, TOMATOES, GRAPEFRUIT . . . or raw cabbage or salad greens. At least one serving a day.

POTATOES AND OTHER VEGETABLE AND FRUITS . . . raw, dried, cooked, frozen or canned. Two or more servings a day.

MILK AND MILK PRODUCTS... fluid, evaporated or dried milk. One quart (or its equivalent) a day for children and expectant or nursing mothers; one pint a day for all others.

MEAT, POULTRY, FISH OR EGGS...or dried beans, peas, nuts or peanut butter. One serving of meat, poultry or fish a day, occasionally peas or beans instead. Three or four eggs each week.

BREAD, FLOUR, CEREALS . . . natural whole-grain or enriched or restored. Three or more servings a day.

BUTTER AND FORTIFIED MARGARINE . . use for spreads and for seasoning as you like and as supplies permit.

In addition, all growing children and all expectant or nursing mothers should be provided with 400 units a day of Vitamin D in the form of Vitamin D milk (fresh or evaporated), fish liver oil or Vitamin D concentrate

SPECIAL OPPORTUNITY!

15 Months of Membership Privileges for 1946 New Members

PARTICULARLY TODAY, who does not welcome an authoritative base for intelligent opinion and action?

The NOPHN collects FOR YOU the latest information on public health nursing from nationwide studies, surveys, field visits, correspondence, and committee work so that it can help you with your perplexing problems. The NOPHN Publications List shows you the many reprints that are free to members. *P h n*, the membership quarterly bulletin, keeps you informed on just what your Organization is doing in its program to help you. Loan folders and the free use of National Health Library facilities are yours for the asking, available to help solve your problems.

> ***Important to you:*** **Membership dues are payable on a calendar year basis. However, from October first, dues received cover the remaining three months of 1945 and the next full calendar year. All membership privileges begin just as soon as dues are paid and the applicant accepted to membership. This is a 25 percent increase in the period of time during which to avail yourself of membership privileges.**

Fill out the box below and join the ranks of public health nurses doing a better job because they are better informed!

National Organization for Public Health Nursing
1790 Broadway, New York 19, New York

☐ **I want to join the NOPHN for 1946, and enclose $3. Please enroll me as a:**
☐ **nurse member** ☐ **general member**

☐ **I want to subscribe to PUBLIC HEALTH NURSING magazine at the special membership rate and enclose $2.**

Name .....

Street .....

City ..... **Zone No.** ..... **State** .....

There will always be

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REG. U. S. PAT. OFF. AND CANADA

for Young Women in White

TO INSURE BEAUTIFUL...COMFORTABLE...HEALTHY FEET

$6.00 to $7.00

In Canada $8.00 to $10.00

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CONNECTICUT
Bridgeport: D. M. Read Co.
Hartford: Sage-Allen and Co., Inc.

DELAWARE
Wilmington: Kennard-Pyle Co.

DISTRICT OF COLUMBIA
Washington: Frank R. Jelleff, Inc.

FLORIDA
Jacksonville: Cohen Bros.
Pensacola: Meyer Shoe Co.

GEORGIA
Atlanta: Rich's, Inc.
Augusta: Saxon-Cullum Co.
Columbus: Miller-Taylor Shoe Co.
Macon: Arnold Shoe Co.

IDAHO
Moscow: David's, Inc.

ILLINOIS
Chicago: Marshall Field and Co.

INDIANA
Indianapolis: Geo. J. Marott
South Bend: Robertson Bros. Dept. Store

IOWA
Des Moines: Field Shoe Co.
Dubuque: Walker Bros., Inc.
Sioux City: T. S. Martin Co.
Waterloo: Walker's Shoe Store

KANSAS
Wichita: John Braitsch Shoe Store
Wichita: Jones-O'Neal Shoe Co.

KENTUCKY
Lexington: Baynham Shoe Co.
Louisville: Baynham Shoe Co.

LOUISIANA
New Orleans: Imperial Shoe Store
Shreveport: Phelps Shoe Co., Ltd.

MAINE
Portland: Davis and Cartland Co.

MARYLAND
Baltimore: S. Dalsheimer and Bro.

MASSACHUSETTS
Boston: Wm. Filene's Sons Co.
Springfield: Forbes and Wallace, Inc.
Worcester: Denholm and McKay Co.

MICHIGAN
Detroit: J. L. Hudson Co.
Flint: Rowe's Walk-Over Boot Shop

MINNESOTA
Duluth: Duluth Glass Block Store Co.
Minneapolis: The Dayton Co.
Minneapolis: Home Trade Shoe Store
St. Paul: The Emporium Merc. Co.

MISSISSIPPI
Jackson: R. E. Kennington Co.

MISSOURI
Kansas City: Robinson Shoe Co.
St. Louis: Famous-Barr Co.

NEBRASKA
Omaha: J. L. Brandeis and Sons

NEVADA
Las Vegas: Ronzone's Dept. Store

NEW HAMPSHIRE
Portsmouth: Shaine's

NEW JERSEY
Elizabeth: Ruthal's
Hackensack: Stenchever's
Newark: Hahne and Co.
Passaic: Stenchever's
Paterson: Stenchever's
Trenton: Ruthal's

NEW MEXICO
Albuquerque: Paris Shoe Store
Santa Fe: Pflueger's

NEW YORK
Brooklyn: Frederick [illegible] Co.
Buffalo: Flint [illegible] Kent
New York: Bloomingdale Bros., Inc.
New York: Stern Brothers
New York: John Wanamaker
Rochester: Wm. Eastwood and Son Co.
Syracuse: Park-Brannock Shoe Co.
Utica: C. Sautter's Sons

NORTH CAROLINA
Durham: R. L. Baldwin Co.
Salisbury: Phil's Family Shoe Store

NORTH DAKOTA
Fargo: The O. J. deLendrecie Co.
Grand Forks: Rand Shoe Co.

OHIO
Akron: The M. O'Neil Co.
Cincinnati: Potter Shoe Co.
Cleveland: The May Co.
Columbus: The F. and R. Lazarus and Co.
Dayton: The Rike-Kumler Co.
Springfield: Nisley Shoe Co.
Toledo: The LaSalle and Koch Co.
Youngstown: The Strauss-Hirshberg Co.
Zanesville: J. E. McHenry Shoe Store

OKLAHOMA
Oklahoma City: Kerr Dry Goods Co.

OREGON
Portland: Meier and Frank Co.

PENNSYLVANIA
Philadelphia: S. Dalsimer and Sons
Philadelphia: Strawbridge and Clothier
Philadelphia: John Wanamaker
Pittsburgh: Kaufmann's
Reading: Manning-Armstrong
Scranton: Lewis and Reilly, Inc.

RHODE ISLAND
Providence: The Outlet Co.

SOUTH CAROLINA
Charleston: Jas. F. Condon and Sons, Inc.
Columbia: Saxon-Cullum Co.

SOUTH DAKOTA
Aberdeen: Webb-Carter Shoe Co.
Sioux Falls: Johnson Shoe Co.

TENNESSEE
Memphis: Walk-Over Shoe Store
Nashville: Baynham Shoe Co.

TEXAS
Austin: E. M. Scarbrough and Sons
Dallas: A. Harris and Co.
Dallas: Sanger Bros.
El Paso: The Popular Dry Goods Co.
Fort Worth: Fair Dept. Store
Fort Worth: W. C. Stripling Co.
Galveston: E. S. Levy Co.
Houston: Krupp and Tuffly, Inc.
San Antonio: The Guarantee Shoe Co.

UTAH
Salt Lake City: Z. C. M. I. Dept. Store

VERMONT
Rutland: Wilson Clothing Co.

VIRGINIA
Newport News: Adams Shoe Store
Norfolk: Hofheimer's, Inc.
Richmond: Miller and Rhoads, Inc.

WASHINGTON
Seattle: Frederick and Nelson
Spokane: Spokane Dry Goods Co.
Tacoma: Rhodes Bros.

WEST VIRGINIA
Charleston: Peoples Store, Inc.
Wheeling: Alexander and Co.

WISCONSIN
Milwaukee: Milwaukee Boston Store, Inc.

WYOMING
Cheyenne: Wasserman's Shoe Store

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